GUY'S HOSPITAL GAZETTE NEW SERIES VOL 2 1877

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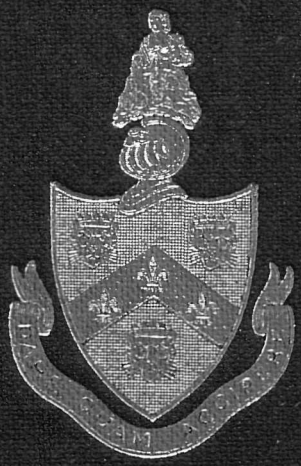

Guy's Hospital Gazette.

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March 1878

Guy's Hospital Gazette.

A STUDENTS' JOURNAL OF HOSPITAL NEWS, MEDICINE, AND SURGERY.

VOL. II.—NEW SERIES.

1877.

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A Students' Journal of Hospital News, Medicine and Surgery.

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Clinical Lecture

ON HIP JOINT DISEASE.

By Mr. A DURHAM.

(Continued from page 137.)

Hip joint disease goes on insidiously but surely until it reaches the *second stage* or that of effusion with distension of the capsule.

The pain is now much increased, so that the child is scarcely able to limp. Patient rests the affected on the opposite limb and tries to steady it with its hand. The health suffers severely; if the child go to sleep the muscles of the limb are relaxed, the leg falls, and the child wakes up with a scream. The position of the limb in this stage is very uncertain; it may still be slightly abducted, flexed and rotated outwards, but it may be beginning to become adducted and rotated inwards. There is apparent shortening and much wasting of the muscles especially in the gluteal region. The fold between the upper part of the thigh and the gluteal region below the buttock becomes lost, but this occurs sometimes as an early, sometimes as a later symptom. There is also a flattening and broadening of the gluteal region.

The mode of treatment.—This is the same as in the first stage, but fomentations and poultices containing strong anodyne preparations may be used with advantage.

The material effused depends on the character of the inflammation; it may be either 1, serous; or 2, pus.

If the former, we may still hope by perfect quiescence to obtain absorption with good recovery, counter-irritation being often a valuable aid in effecting this.

If not cured, the disease passes into the *third stage*, or that of "diffusion with rupture of the capsule." This occurs only when pus has been effused, causing ulceration and rupture of the capsule. An abscess now forms outside the capsule, and this may occur even when the capsule is not ruptured.

The disease has now spread both to the cartilage and bone, and recovery is generally doubtful and always slow.

The limb is adducted, much flexed, and rotated inwards, although exceptional cases occur in which it is straight and rotated outwards. There appears to be, and is, real shortening to a greater or less extent, depending, probably, on loss of material about the head of the femur and the acetabulum.

In this stage the cartilage is destroyed and the bone softened, especially about the neck of the femur, while the muscles draw the bone up, causing it to be shortened. There is now less pain than in the former stages, except on attempting to move the limb, but the health greatly suffers, and there is general febrile disturbance.

Treatment.—You may still get recovery in a modified form as an anchylosis, and hence you aim at putting the limb in the best possible position and keeping it at rest during a protracted time.

When the superficial structures are tense make a free opening in them and evacuate the pus. After, however, excision is necessary, and when this fails the grave operation of amputation becomes the only chance of saving the patient's life.

Clinical Lecture.

By S. O. HABERSHON, M.D.

October 14th, 1876.

MORBIS CORDIS.

Rarely is there a better opportunity of studying aortic imperfection than in the Clinical Ward at the present moment, in which four or five interesting cases are to be seen.

The first patient which I will bring before your notice is the following:—

C. F., Clinical 2, admitted 4th October, 1876, a carman, liable to much exposure in all weathers. Family history good; no history of gout or rheumatism in the family. Patient is single, and had always enjoyed good health until 2 years and 9 months ago, when he suffered from a mild attack of rheumatic fever for which he was treated at home. As soon as he was able to get about he came to this hospital as out-patient, complaining of weakness and fluttering of the heart. He attended for eight weeks and got much better, returning then to his work. He kept perfectly well, and got rid of the shortness of breath which troubled him a little after his illness. Has never had winter cough, nor at any time expectorated blood. Has drunk hard at times, but has never had any venereal affection.

About 3 months ago he noticed that he was rapidly losing his appetite, and feeling very weak and nervous. This was followed by pyrexia and rheumatic pains in the joints generally. Does not remember having got wet previous to the attack, but owns that from his employment he was much exposed to all weathers. After being laid up in bed at home for a fortnight, he again attended as an out-patient at this hospital seven weeks ago. For the last fortnight he has suffered much from shortness of breath, and has noticed that his feet and legs have been swelling. The swelling he noticed in the evening after he had been about all day, and after a night's rest he found that it had disappeared. For the last few weeks has been rapidly getting paler, and losing flesh. He also complains of palpitation, shortness of breath, and increasing weakness. Has a bad cough and profuse expectoration of muco-purulent matter for the last month. Perspires freely, especially at night. For three nights is unable to lie down in bed on account of his very troublesome

cough, and the dyspnœa increasing when in a recumbent posture. Has had little sleep for the last few days.

On admission.—Patient is a very anæmic, thin young man of average height. He sits propped up in bed, that being the position in which he is most at ease. Eyes, fairly bright; pupils, moderately dilated; conjunctiva, bluish; vessels, rather distinct. Tongue pale and slightly furred at the sides with a white fur. Appetite moderately good. Digestion slightly impaired. Bowels rather relaxed.

Chest.—Moves fairly well in respiration. On percussion anteriorly over both lungs there is good resonance, except where the increased pericardial dulness masks the lung. Posteriorly there is good resonance all over the right and over the upper half of the left chest. The breath sounds are harsh, and sonorous rhonchi are generally audible. Below the angle of the left scapula there is well marked dulness, merging at the lower border of the lung into complete dulness. Breath sounds are distant and there is well marked œgophonic bronchophony. The cough is hacking and troublesome. The sputa are muco-purulent in character.

The heart dulness is much increased downwards and outwards. It is difficult to define its extent because it merges into the dulness of the base of the lung. The apex beat is $2\frac{1}{2}$ inches below the nipple. and fully 1 inch to its outer side. In the fourth interspace, as the heart strikes the wall, there is a sucking in of the parietes which closely corresponds to the heart's action (adherent pericardium). The heart's impulse is very diffused, irregular, and apparent. On auscultation at at the apex, the heart is found to be very irregular in action, and it is impossible to distinguish with certainty the various bruits. There is undoubtedly an apex systolic, harsh whiffing bruit. This is accompanied by another bruit which appears to be conducted down from the base where the systolic bruit is still audible, but not to the same marked degree as at the apex. The sounds at the base are muffled, and there is some doubt as to the existence of a double bruit.

Liver dulness increased, and the organ extends for about an inch below the margin of the ribs; no pulsation can be felt.

Spleen seems pushed down by the effusion at the base of the left chest.

Urine, sp. gr. 1032, abounding in lithates. On boiling, these disappear, but a faint cloud appears on further boiling. This disappears on addition of nitric acid.

Temperature, 100·8°; pulse, 88, very irregular and occasionally intermittent. No venous pulsation anywhere. Œdema of feet and legs as high as the knees. Evening temperature, 101°; pulse, 120.

Ordered Tr. Scillæ ♏x. Tr. Digitalis ♏x. Mist. Senegæ ℥j. iv. tis horis. Beef-tea, cocoa, fish or chop and stimulants (should necessity arise).

Under the influence of medicine and rest the patient gradually improved, the heart became more composed and regular in action.

October 13th (10 days after admission).—Heart dulness now more accurately to be made out, as the lung is clearing up. It commences at the lower border of the 3rd rib, and extends down as far as the lower border of the 6th rib. Laterally it extends from the midsternal line to fully 2 inches outside the left nipple. Heart's action much steadier. A distinct thrill is to be felt over the apex beat, and on auscultation a triple sound is distinctly audible. The systolic bruit is very loud and whiffing, and is heard over a large area behind. The diastolic bruit is still more audible this morning over the aortic valves. As the ear travels down to the apex, the loud, blowing character of the systolic murmur quite masks the diastolic bruit, and three sounds are heard, viz., a loud, blowing murmur replacing the 1st sound, followed by two thick and rapid sounds. Pulse less irregular, 76; respiration, 30.

The sphygmographic tracing shows aortic imperfection.

This young man suffered from rheumatism leading to disease of the valves, especially the aortic, though there is also dilatation of the mitral orifice. Probably in his first attack the aortic valves became œdematous, then thickened. At the margins of the aortic valves at the double crescents a deposition first took place, the valves became thickened, and this thickening increased with each fresh deposition of fibrine.

In addition to the thickening mentioned, the edge of the valve was probably puckered and drawn in, so that it does not completely close the orifice. The ventricle has had double work to perform and dilates. The mitral valve then became affected from over distension, some rheumatic thickening also existed there, but in the above case the aortic valve was the one principally diseased, giving rise to ventricular dilatation.

In heart disease the condition of the muscular fibre of the heart is the most important consideration; whether the ventricle is dilated and hypertrophied, and whether the hypertrophy *keeps pace* with the dilatation. In this case the ventricle is both dilated and hypertrophied.

The symptoms differ according as the *right* or *left* ventricle is dilated. If the right is affected, the symptoms indicating general venous congestion are present; if the left, the countenance may be pale and anæmic. If the dilatation is on the left side there is increased impulse, throbbing, and palpitation, the apex beat is lower than it would normally be, and one inch or perhaps two inches to the left of the nipple. The patients suffer much from distress, from clammy perspiration, urgent dyspnœa, and perhaps syncope. There is pallor of the face and lips. The dulness on percussion is found to be unusual in extent, and if the heart is unable to empty itself death may occur from syncope.

Should there be aortic obstruction, a systolic bruit

will be heard over the aortic orifice, and there will be a small pulse at the wrist.

If there is aortic insufficiency, a bruit is heard as the blood returns—a diastolic bruit,—and with this there is a sharp water-hammer pulse. The vessels are imperfectly filled, hence the pallor, hence the giddiness and faintness. When the aortic valves are affected, the murmur is heard in the direction of the aorta, viz., upwards and to the right, and downwards along the sternum. There is throbbing in the carotids and other vessels of the neck. If the *right* ventricle is dilated there are venous turgescence of the face, livid lips, suffused conjunctiva; and if the tricuspid valve be imperfect, then there is pulsation in the veins of the neck, distension of the superficial veins, and evidence of systemic obstruction. On percussion the dulness is increased towards the sternum, and extends over the scorbiculus cordis; the pulsation may be transmitted through the liver, as reported in a paper by Dr. Taylor in the Guy's Hospital Reports.

In the above case rheumatism was the cause of the disease of the heart; another not unfrequent cause is muscular exertion, as in the case of a sailor to be mentioned directly. Constant tension of the valve leads to gradual imperfection, and perhaps perforation, or it may be inversion of the valve. Dr. Addison used to call attention to the frequency of this disease in those accustomed to row barges on the river, but it is also produced by other forms of violent exercise. These causes may either of them produce aortic imperfection and hypertrophy of the left side of the heart, or the two may be combined, as in one case to be noticed. In other instances we find hypertrophy and dilatation without any valvular disease.

Treatment.—The treatment should be to keep the patient thoroughly quiet, removing every strain upon the heart, to gently unload the bowels without straining at stool. If the heart acts irregularly, or the mitral valve is imperfect, small doses of digitalis should be given, but this remedy is less value in aortic than in mitral disease.

In the above case digitalis was given with a little squills, and senega on account of his troublesome cough and the implication of the mitral. The patient seems recovering, and though the imperfect aortic valves can never be restored, yet as long as the hypertrophy keeps pace with the dilatation, no distress is necessarily felt; but the danger always exists of sudden cessation of the heart's action from over distension.

(To be continued.)

Physical Society

Meeting December 2nd, 1876,

The fifth meeting of this Society was held on Saturday, December 2nd, when Mr. C. K. SHAW read a paper on "Pyrexia and method of reducing it;" of which the following is an abstract.

There are two theories as to the origin of fever: one that the blood is primarily affected; the other that fever is primarily caused by derangement of the nervous system.

In specific fibrile diseases there is a distinct and separate specific poison originating outside the body and by some means getting into the blood.

Increase of temperature is due to a morbialy active combustion of the tissues of the body, caused by some poison acting immediately on the blood and tissues, or by blood circulating through an inflamed part. Increase of temperature in lesions of the nervous system is not equivalent to fever.

Tissue waste is shown by the increased discharge of the nitrogenous elements (Urea) of the body. The amount of urea discharged being three times more than that of a healthy person.

It has been conclusively proved that more heat is really produced than in the normal state.

Nature gets rid of the superfluous heat by sweating from the skin, and very slightly by respiration. The heart's action being increased, more hot blood is sent to the skin to be cooled. The temperature is often naturally reduced by hæmorrhage from the lungs, stomach, and intestines, and by vomiting and diarrhœa.

Cold Baths should be given frequently and perseveringly, night and day, whenever the temperature rises above 104°. The patient should remain for about twenty minutes in a bath of 95°, gradually cooled down to 72°, or below.

Antipyretic drugs should be used with baths to avoid the frequent necessity of using them.

Baths are contra indicated in a high degree of weakness of the heart, loss of blood and perforation of the bowels. Mensturation and pregnancy, pneumonia and bronchitis are not.

Quinine acts directly on the blood, checking the activity of cells and causing a decrease in the oxidation and disintegration of the elements of the body. Should be given in large doses, from 8 to 48 grains. It is best given in a 48 grain dose, repeated in two days.

Salicylic Acid and Salicin are anti-pyretics and anti-zymotics, and act in a somewhat similar way to Quinine They should also be given in large doses from 10 to 60 grains at once.

In a febrile attack 20 grains may be given every two hours. Salicylic Acid can be dissolved Liq. Ammon. Acet. and Salicin in hot water.

Aconite weakens the heart causing less rapid circulation, and so less oxidation, and by dilating the capillaries sends more blood to the skin to be cooled.

Minims doses of the tincture should be given every hour or more frequently. Of most value in uncomplicated inflammatory diseases.

Veratria and Digitalis act similarly. Of Veratria

one twelfth of a grain should be given every two hours until decided nausea occurs. Of Digitalis ten to twenty grains should be gradually given during 24 or 30 hours.

Alcohol lessens oxidation, dilates the capillaries, and checks fermentation. Very large doses are required to produce only a slight fall of temperature.

Mr. UHTHOFF opened the debate by remarking that Mr. SHAW should have noticed the condition of the organs after death from Pyrexia. They are often swollen and friable from the presence in them of albuminoid and fatty particles. With regard to the action of drugs, Mr. UHTHOFF thought that Hydrate of Chloral in large or fatal doses caused loss of temperature; mentioning experiments on rabbits in support of his theory. He thought Mr. SHAW had confused Veratria and Veratrum Viride, the two drugs being different in action, for Veratria is said not to lower the temperature. Salicin had been tried and found of but little use; in one case, however, he had seen good results from it. He considered that the temperature was lowered in the cold bath by direct abstraction of heat from the body.

Mr. HORROCKS remarked that though the increase of heat was to be feared in Pyrexia, elevation of temperature caused few deaths in comparison with the number resulting from other causes. He looked upon the blood as a fluid rich in organic and organised structures, and readily affected by poisons which acted perhaps as ferments. Though the temperature might be lowered, the so called "fermentation" was not thus checked, and this was therefore more or less useless, as the poison continued to act.

Mr. HARTLEY thought that nature had a tendency to overleap herself; she did so in inflammation in her efforts to eliminate morbid material. He also thought Mr. SHAW might have mentioned the antiseptic treatment in traumatic fever, as he considered such treatment had great influence on fever after operations. With regard to the cold water treatment he thought its beneficial results had been wonderfully overrated. He had known the subcutaneous injection of Quinine produce wonderful results in a case of sun-stroke. He also mentioned the Coca leaf as a remedy that might be employed in case of Pyrexia.

Mr. DAVY observed that little had been said about the white corpuscles of the blood. That traumatic fever seemed to be caused by emigration of these corpuscles and their proliferation, and that in other forms of fever the same emigration probably took place. That in scarlet fever the whole stroma of the back of the tongue, kidneys, &c., were covered with white corpuscles. Peyer's patches showed the same thing in enteric fever. Probably other chemical changes were produced, also giving rise to Pyrexia. The amæboid and other changes in white corpuscles undoubtedly went on more actively at the temperature of 103° or 104° then at lower temperatures. That lowering the temperature of the body therefore tended to prevent cellproliferation was certain, but in his opinion other symptoms, such as the affection of the throat in scarlet fever, or asthenia in continued fever are more to be dreaded than high temperature.

Mr. RUSSELL remarked that in Dr. BRUNTON'S book there is an exhaustive account of the action of Quinine in fever, or septicæmiaœ. From experiments made he concluded that Quinine was the best drug for destroying Bacteria, although when injected into the veins it often failed. Experiments had also shown that Quinine injected into a frog's foot prevented the emigration of white corpuscles. Moreover Dr. L. BRUNTON had found that Quinine checked oxidation in the living body, and thus prevented a rise of temperature. Mr. RUSSELL considered Alcohol valuable in fever cases, not as a febrifuge, but in order to aid digestion of food.

Mr. MEEK believed small pox and other specific fevers to be parasitic. That the parasites could not be seen even with the microscopes in present use was true, but that this was not surprising when we remember that Prof. TYNDALL by two distinct processes of reasoning came to the conclusion that if a drop of water were magnified to the size of the world each of the atoms composing it would be of the size of a cricket ball. He believed the high temperature in Pyrexia to be due to the effect of fever upon the nerve centres, and that Hyperpyrexia was the result, rather than the cause, of Bulbar paralysis. That the good effect of cold baths was principally due to their effect on the nervous system, though of course to a slight extent they might lower the temperature by being of a lower temperature themselves. That he could see but one similarity between Salicin and Salicylic acid besides in their name, and that was in neither of them being of much use.

[We regret that want of space obliges us to postpone the report of the meeting held on the 16th ult. until our next issue.]

Faradaic Electricity,

BY JOHN HENRY SANDY,

Electrician to the Hospital.

In the year 1831, in pursuing investigations into the phenomena of electricity, Faraday was led to infer that, as a current of electricity induces magnetism, the magnetic force would induce electricity; and, aided by the previous discoveries of Œrsted, Ampère, Arago, Davy, and others engaged in scientific research, he was enabled, in the same year, to prove the correctness of his ideas, and to establish that branch of electrical science so justly bearing his name.

To make this paper intelligible, it will be necessary to briefly glance at some of the discoveries immediately antecedent to Faraday's.

The close relation existing between electricity and magnetism had been discussed at an early period of its history; Franklin and his contemporary electricians had communicated magnetism to small steel bars by the charge of an electrical battery, and the power that electricity exerted in destroying, restoring, and reversing magnetic polarity was also known. In 1807, Œrsted, in a work treating of the analogies between electricity and magnetism, says, "In galvanic action the force "is more latent than in electricity, and it is still more so in "magnetism than in galvanism. It is necessary, therefore, "to try whether electricity in its latent state will not effect "the magnetic needle." In 1819, twelve years after, Œrsted followed the course that he himself had indicated, and by bringing a magnetic needle over a wire charged with galvanic electricity (that is to say, connected to a galvanic battery), found that the conducting wire itself was magnetic during the time it was charged, and lost its magnetic influence instantly on being disconnected from the battery.

If the conductor be placed above the magnetic needle and the current be made to traverse it from north to south, as shown in figure 1, the needle will be immediately deflected from its point of rest, taking up an easterly position. CZ represents a galvanic pair or battery: A the conducting wire, the arrows indicating the direction of the current flowing from the battery, and N S represent the north and south poles of the magnetic needle. If the conductor be placed under the needle it will be deflected to the west, which will also be the case if the current traverse the wire in the opposite direction. Almost as soon as Œrsted's great discovery was made known, Ampère and Arago succeeded in multiplying this power by binding the wire round the needle, as shown in figure 2, and this was again followed by a number of convolutions of wire being made to surround the needle, as in figure 3; thus the foundation was laid for the instrument known as the galvano-

meter, used to detect and measure currents of galvanic electricity, and the first electric telegraph of Cook and Wheatstone owes its origin to the same experiments.

To further illustrate that the electrified wire is itself magnetic, twist about two feet of cotton or silk covered wire round a pencil, so as to form a kind of spiral spring when the pencil is withdrawn; balance the coil horizontally on a needle, as shown in figure 4, each end of the wire being allowed to dip in a circular cup of mercury (indicated by the dark rings in the sketch), so that they may move round freely; on connecting a galvanic battery to the mercury, as shown by Z and C, the spiral of wire will gradually place itself in the magnetic meridian, and will resemble a permanent magnet in all respects during the time the current is allowed to flow, and when that ceases the wire will instantly lose its magnetic influence. If the wire be wound round a bar of soft iron and poised in the same way the magnetic influence will be vastly augmented, but it will still lose its magnetic power when disconnected from the battery. This forms a bar electro-magnet of the ordinary character.

Although these important discoveries had been made, it was left to Faraday to discover the connecting link in the chain, and *determine* the relation existing between electricity and magnetism. He found that if a bobbin of wire, similar to that at figure 4, was placed between the opposite poles of two long bar permanent magnets, the ends of the wire being connected to a galvanometer, as shown in figure 5, the instant the poles of the magnets were separated at C, as shown by the dotted lines, the galvanometer under C was momentarily deflected, and after oscillating for a short time returned to its normal point of rest; and upon bringing the extremities of the magnets again together the same effect followed, except that the galvanometer needle was deflected in the opposite direction. He also found that if the bobbin was wound round a bar of soft iron, and subjected to the same experiment, the power was much increased; and, again, if the extremities of the bobbin were reserved. by A being turned to N and B to S and *vice versâ*, without disturbing contact at C, the needle was deflected from right to left; and also, if a permanently magnetised bar of steel was suddenly thrust into a similar bobbin of wire and as suddenly withdrawn, the same phenomenon was manifest (see figure 6).

Faraday's next discovery in relation to the subject under consideration proved that, if two wires be placed in close proximity to each other, without actual contact, and a current of galvanic electricity passed through one wire, a current lasting for an instant only is induced in the neighbouring wire, and upon breaking contact the same effect follows, but the induced current traverses the wire in the opposite direction to that upon making contact, see figure 7; A is a wire, one end of which is connected to Z (the zinc or negative pole of the battery, the other extremity being connected to the contact-breaker (D) at E, the positive pole of the battery (C) being connected to D at F; this is termed the *primary* or *electrified* wire, and J is a galvanometer put in circuit; B is the *secondary* or *neighbouring* wire, and G also a galvanometer in circuit upon that wire. As the arrangement stands in sketch there is no current passing over either wire in consequence of a disconnection at H, but if the key (H) be pressed down upon plate P a galvanic current will immediately flow over wire A in the direction of the arrows, deflecting the needle J to the right, and the needle G will at the same time be *momentarily* deflected to the left; I will remain deflected so long as contact is kept up at H, but upon breaking contact G will be again momentarily deflected, but now to the right instead of the left, and J will at the same instant return to its point of rest; so that we have a precisely similar result to that sh wn at figures 5 and 6, but due, as far as we know, to the unassisted action of a galvanic current. I may here remark that it was this law of induction, when only imperfectly understood, that was a source of extreme trouble in the working of the early submarine telegraph cables; the water, or the protecting wires round the conducting wire, affected the delicate instruments used for manipulation. Faraday further found that, not only does an electrified body induce electricity in a neighbouring one, but that an electrified wire will induce a current in itself. Upon suddenly disconnecting the wire at either end, C or Z in figure 1, we should discern a very feeble spark at the point of contact. If the same experiment be tried at figure 4 a much more brilliant spark will result, and if we insert a bar of soft iron into the spiral of wire and repeat our experiment we shall find the spark again augmented. The explanation is this: In the first place we have, with the short wire, the decomposition of a particle of the wire last in contact with the battery, by the sole action of the battery; in the second experiment we get increased combustion of the metal from the inductive action of each bend or coil of the wire upon its neighbouring coil; and in the third case we have, in addition, a current induced in the whole of the spiral of wire by the soft iron core suddenly losing its magnetism, as in the case of the permanent magnet being suddenly withdrawn in figure 6.

We have seen, from these simple experiments, that an electrified body is endowed with magnetic properties, which it communicates to neighbouring bodies; that magnetism will induce electricity; and further, that an electrified wire induces electricity, not only in another wire in close proximity to it, but excites the same force in itself under certain circumstances.

Not only, therefore, are we indebted to Faraday for the instruments used in the application of induced currents as a remedial agent, but the beautiful and useful little instrument, "Edison's Electric Pen," by which I am enabled to illustrate this paper, owes its origin to him. The same may be said of the gigantic electro-magneto machines employed to illuminate our light-houses, and thus the same innate force residing in the delicately balanced needle of the mariner's compass was, by this connecting link between the two forces, made not only to guide him, but by its brilliant light to warn him of a far distant danger.

In my next paper I will endeavour to explain how these laws have been brought to a practical use.

Correspondence.

TO THE EDITOR.

Sir,

Might I reply to a letter which appeared in your December number, relative to the inconvenient crowding of the Surgical Out-patients' Room. No doubt the case of W. E. G. needs a little commiseration, but is he to be satisfied at the expense of the first year's man, whose case is not to be carelessly set aside in the present state of affairs? A large number of Students who enter the Hospitals nowadays come straight from our Public Schools with no more idea of medicines or surgery than crossing sweeping; many have never even heard of Syphilis and would be totally at a loss if they had to know whether it were in the province of Medicine or Surgery.

Will Anatomy, Physiology, or Chemistry in any way help them to solve the question?

Would a man be doing the best for himself in discarding the out-patients' room in his first year? The professional education is short enough already without clipping it shorter.

In conclusion, I would refer W. E. G. to page 39 of prospectus where first year's men are distinctly advised to attend occasionally at out-patients' room, that is, I suppose, about once a week, and there are somewhere about 100 first year's men, so that the advice, if properly attended to, would be a greater thorn in W. E. G.'s pillow than I'm afraid it is now.

I am, Sir,

Yours very truly,

A. K. M.

GUY'S HOSPITAL GAZETTE, *JANUARY*, 1877.

ANOTHER Christmas-tide has passed away amid general jocularity and mirth. Holidays are far more frequent than they were a few decades ago, perhaps they are more a necessity by our high-pressure life, people are clamouring for more play and tacitly asserting their determination to do less work, a state of things which has recently resulted in the institution of the so-called Bank Holidays. But these, although the season of the year is ordinarily in their favour, are not enjoyed with the zest and universal hilarity which characterises the period of "Goodwill towards men."

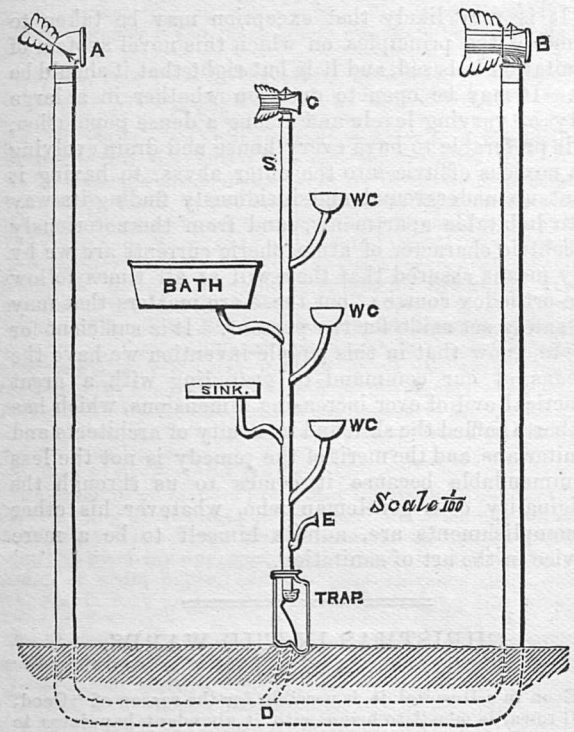
Decorations were a pleasing feature on the festivities at Guy's this Christmas. Holly, Evergreens, Moss and Ferns interwreathed and interlined were tastefully arranged in festoons and other designs of decorative art. Appropriate mottoes, texts, crests with other pretty and quaint devises bore testimony to the industry and skill of the Sisters and Dressers of their respective wards, nor are patients idle, such work and at such a time is done by them very willingly, they feel that they too are of some sort of use in the world and that they are yet capable of partaking of the pleasures of the time, even though they are shut up in a Hospital. On the whole we are bound to consider the decorations this year as more successful than they have been for a long time past, and those who gave themselves the trouble to assist may rest assured that their labours are fully appreciated.

We believe very fully in aiding people more especially the sick nnder our care, to make the most of the rare periods of enjoyment that fall to their lot. Life taken in the bulk is not such a very enjoyable affair for most of us in health, and we may all assume *a fortiori* that an invalided life is very much less so. This is the best reason we can give for making the wards look brighter and pleasant at yule-tide, and we trust and believe that our trouble this year was not thrown away, that our patients were as thoroughly happy as persons confined to their beds for sickness can well be.

Sanitary Improvements at the Hospital.

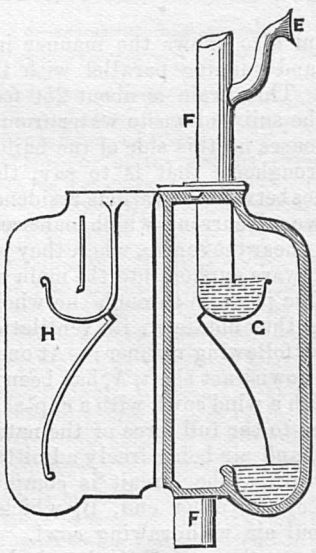
We redeem a promise to our readers to give a more lengthened notice of the alterations made on the east side of the hospital, with the view of improving the sanitary condition of the surgical wards, and which were referred to in a previous number. We may as well premise, that, prior to the adoption of the "Banner system," much had been done to render the sewers in this division of the hospital more efficient, by the substitution of glazed earthenware pipes for the numerous brick-barrel drains which had been made to do duty for an indefinite period. These latter were found in many parts of their course to have suffered from decay and consequent leakage, mainly attributable to the energetic incursions of successive colonies of rats, which appear to have retained an undisputed possession of the stygian domains for upwards of a century, and, probably, as long as the hospital has existed. After securing a free current for the soil underground, to its point of junction with the Metropolitan sewers, it became a question of not less moment, how the escape of sewer gas into the wards and other residences was to be prevented; or, in other words, how the soil pipes and minor conduits leading to the drains, as well as *the drains themselves, were to be ventilated.* Now, in nearly all private houses, and certainly in all public institutions, the reflux of sewer gas into the habitable apartments is restrained, or sought to be restrained, by means of valves or traps placed immediately under and continuous with the soil pipe of the w.c., and the ingenuity of plumbers and of sanitary engineers has been taxed to the utmost to discover the best apparatus for this purpose. An infinite variety of syphons are consequently in use, each professing to impose a sealed barricade on the noxious intruder, but experience, of late years especially, has shown that, under certain conditions of the weather, both above and below ground, the supposed safeguards are not only valueless, but very often mischievous. It has also been repeatedly shown that the D trap, in such universal use, becomes in time so encrusted with deposits from the soil, as to prove a source of danger of itself, independent of its faulty action. In what is unquestionably the best w.c. yet introduced,—viz., Jennings' Patent Valve—in which the basin and trap are made in one piece of imperishable earthenware, and provision is made for continuous flushing, the inventor has thought it necessary to supplement the syphon action by a process for discharging a small quantity of disinfecting fluid into the pan every time it is used, mainly with the view of neutralising the pernicious effect of reflux sewer gas from the valve, but it is clear that in all these attempts at removing a nuisance we are beginning at the wrong end. What we wish to effect is, first, a free passage to the soil downwards; and, secondly, an equally free exit to the sewage gases upwards and at the same time to render them perfectly innocuous by free admixture

with the external atmosphere. How this has been done at the hospital through Mr. Banner's intervention may be partially seen from the accompanying sketch intended to illustrate the manner in which the soil pipes are ventilated, and also, though in a necessarily less perfect manner, the means adopted for securing a free circulation of air in the drains.



A—Inlet to admission air shaft to drain.
B—Outlet to extraction shaft from drain.
D—Drain.
C—Outlet for air from soil pipe.
E—Inlet for fresh air to soil pipe.
S—Soil pipe.

The main object sought for is a continuous atmospheric current, which, when once obtained, must carry the mephitic nuisance, in a highly diluted form, free out of harm's way above the level of the roof. In the case of the soil pipe, this is effected by the inlet pipe E at its base and by the foul air withdrawing cowl C which surmounts its upper extremity. The inlet pipe is placed immediately above the single trap which guards the communication betwixt the soil pipe and the drain and is fed continuously from the external air, while the cowl is so constructed as to exert at all times a considerable suction-force on the air in the pipe, and thus to maintain a current, variable with the wind's velocity, but still permanent. Nearly every one is familiar with the ventilating tube attached to the soil pipe in private houses, so strongly recommended, and even insisted on by numerous sanitary authorities, to facilitate the escape of sewer gases. This air or safety-pipe is doing good service as far as its limited powers permit, but it cannot be too strongly borne in mind that the contrivance can only act intermittently, and then only under certain fixed conditions. For the most part the air in soil pipes and drains is stagnant, and in this state it is known to vitiate the water in traps, and unless counter openings are made, for the double purpose of admitting and withdrawing air, we have no security against the foul effects of deleterious gases, simply because we are deprived of the means of keeping up an atmospheric current. Again, to prevent any communication betwixt the drain and the soil pipe, and thus nullify the action of the fresh air from the inlet tube, Mr. Banner has introduced a trap of peculiar construction, an illustration of which is given below.



Scale ½ in. / foot.

E—Inlet air pipe.
F—Soil pipe.
C—Double dip trap.
H—Outer plate of trap reversed.

This trap is very simple and effective; it is cast in iron, and in the drawing the outer plate has been reversed so as to show its internal mechanism. One of these traps will suffice for any number of closets placed separately on floors above. There are two underneath the scullery projection of Accident ward, each doing service for four of the w.c.'s of the wards above, and since their introduction they have never been at any time unsyphoned. The trap has a double dip, and, while its depth is only five inches, there is a vertical fall of two feet between the two dips, which would leave a space sufficient to contain a couple of gallons of water, exerting a downward force of over 20 lbs. on the lower dip, while the fall of water from the ward closets has been found amply sufficient to keep the upper dip free from any obstruction.

We have already referred to the wind cowl as the main motive agent for maintaining the continuous upward current. That it does so effectually, by utilising the aspiratory force of the air, is beyond question; but it does more than this. Its suction-force, though mainly employed in extracting the vertical column of air in the soil pipe, is also imparted to the minor conduits connecting it with the numerous soil pans, as has been repeatedly shown by the familiar experiment of holding a lighted taper over the pans to test the direction of the current. From this circumstance Mr. Banner has felt justified in dispensing with the numerous traps, whether metallic or earthenware, attached to each closet, and has thereby got rid of a constant source of annoyance and expense, besides securing us an immunity from an ever fruitful source of danger.

The diagram also shows the manner in which the drain outside and running parallel with the hospital is ventilated. This drain is about 250 feet in length and receives the soil and waste water from the wards and officers' houses on this side of the building. It is continuous throughout, that is to say, there are no syphon obstacles betwixt the various residences to interfere with the two soil currents which coalesce on account of the gradients near the centre, where they pass through a large earthenware syphon into the main sewer of the hospital. A free passage through the whole extent of the drain being thus obtained, its ventilation has been secured in the following manner;—At one extremity of the drain a down-cast shaft, A, has been introduced, surmounted with a wind cowl, with a cup-shaped orifice always exposed to the full force of the natural atmospheric current, and air being freely admitted from this source to the drain, the circuit is completed by an up-cast shaft at the other end, B, which is capped with a large foul air withdrawing cowl. Each shaft rises 10 feet above the roof of the hospital and is over 50 feet in height, so that we have here a channel of 350 feet in length, through which the air is made to traverse always in the same direction, a space dealt with, considering the number of houses and their numerous occupants, equal in extent to the side of a square or division of a street, and from the drain to the large hospital sewer there is but one outlet, which in its turn is guarded both at its entrance and at its point of junction with the Metropolitan sewer by a similar apparatus. It may be noticed that the system of sewer ventilation here referred to is not dissimilar to that employed in coal mines or on board ships, and is the same in principle as that advocated by Desagulier, Reid, Peclet, and their numerous imitators, differing only (and the difference may be considered by many fatal to the theory), in the absence of an intermediate motive force to regulate the currents. So far as our experience enables us to judge, the system appears to fulfil all the conditions specified in the contract, There is no foul air generated in the w.c.'s, the several currents in the soil pipe, in the drain, and in the large sewer have uniformily been found to be flowing in the right direction whenever they have been tested (and this has been done repeatedly), while no inconvenience has arisen from the removal of the numerous traps and other apparatus which were thought to be the only safeguards of our closet system.

It is very likely that exception may be taken to some of the principles on which this novel system of sanitation is based, and it is but right that it should be so. It may be open to question whether in a large city of varying levels and among a dense population, it is preferable to have every house and drain evolving its noxious effluvia into the outer abyss, to having it pent up underground and insidiously finding its way into habitable apartments, and from the notoriously eccentric character of atmospheric currents are we by any means assured that they will at all times follow the orthodox course; but these are matters that may be safely set aside for the present. It is sufficient for us to know that in this simple invention we have the means at our command of grappling with a great practical evil of ever increasing dimensions, which has hitherto baffled the skill and ingenuity of architects and sanitarians, and the merit of the remedy is not the less commendable because it comes to us through the originality of a gentleman who, whatever his other accomplishments are, admits himself to be a mere novice in the art of sanitation.

CHRISTMAS IN THE WARDS.

Even in a Hospital it is possible for the season of "Goodwill towards men" to bring with it abundant happiness to many whose lives are at other times joyless enough. Few would have expected to find so much hilarity among sick people as was heard through the wards on the evening of the 25th, there was good cheer in plenty, and hearts (and stomachs) were filled to overflowing.

The decorations, too, lent greatly to the general carnival effect, and one very noticeable feature about them was the individuality and originality of each ward—scarcely any wards being alike. The Ecclesiastical element predominated in some—especially Clinical and Cornelius; loyalty to the Staff and Dressers in others—as Mary, Charity and Astley Cooper; while the armorial bearings of Thomas Guy were represented no less than three times,—in Clinical, Luke, and Lydia,—and from the variety they presented, it perhaps would not be amiss here to remind the artists that the three heads on the coat of arms are not those of cats, tigers, or leopards, but are supposed to be those of bears.

To take the Wards separately:—Clinical, as usual, is very prettily decorated, the general view being very effective, and evidently the result of much labour: heavy festoons of evergreen, with few white roses sprinkled here and there, were strung from pillar to pillar, whilst up each pillar was trimmed thin wreaths of laurel and holly and at each end of the two wards were suspended appropriate texts worked with rice letters on a scarlet ground.

Philip was decorated with taste, though sparingly; the size of the ward of course not allowing of more being done, but what there was looked very pretty and neat, especially

the arches from which were suspended baskets of moss and everlasting flowers, and the niches above the fireplace which were occupied by designs of high decorative art.

Astley Cooper (Naaman) looked very sumptuous; complete arches composed of holly leaves, strung together on thread, being suspended from the ceiling across the ward along its full length, and around the walls, worked in coloured letters on a pretty background, one might read an appropriate verse from one of Longfellow's poems, and another, also very good, by some unknown poet in the ward. The general effect in the ward was fine, and much labour must have been expended in it.

Stephen, too, looked very pretty and picturesque; each archway being encircled with a thin edging of evergreen, and here and there neat looking devices and texts were arranged along the walls. We must specially mention a very prettily executed text in the central Hall over the fireplace.

Bright, though not so elaborate in its decorations as some of the other wards, looked very bright and nice, bunches of evergreen being scattered here and there to gladden the eye.

Addison and Mary were not behind hand; the former noticeable for its general taste; the latter for its neatness and loyalty, the Divine blessing being craved for Dr. Steele, and long life for the Matron.

Ruth and Barnabas had somewhat to gladden the eyes of the patients, if we may use the expression in connection with these wards, and a great deal to chear the hearts (and stomachs), for along the full length of the female ward was arranged the dining table with seats for nearly fifty patients, male and female, for in the eye wards to day there was to be no division of the sexes.

To turn to the Surgical Wards.

In Cornelius we found a great deal to admire, the decorations evincing great taste and neatness; the panel of each of the windows was covered with crimson cloth, and on it all round the ward ran appropriate texts, the letters beautifully formed of white paper, and over the entrance door was arranged, in very pretty straw letters, "A Merry Christmas to you all."

Accident opposite showed plenty of green, each bed being surmounted by a wreath of holly and laurel.

Lazarus and Martha were prettily decorated, the former with the taste though not completeness of last year; the devices over each bed were very effective, worked in French moss with scattered everlasting flowers; the principal feature in the latter was the splendid Christmas Tree loaded with toys, dolls, animals, tea services enough to set up housekeeping with, musical instruments, &c., indeed so many and so good were the presents suspended from it and placed around that we almost wished ourselves young again to come and share in the good things so kindly and thoughtfully provided.

In Job and Lydia what specially attracted our attention were the beautifully worked texts placed upon the walls—wool letters upon a crimson ground—the work evidently of fair and practised fingers, these with other neat texts and wishes and the tastefully arranged evergreens made both wards look very cherry and bright, the latter one also glorying in a pretty Christmas Tree for the children.

Charity looked very homely and comfortable. Across the ward by the central fireplace was suspended a large white banner with the words "Long live Mr. Cooper Forster and our Dressers" worked upon it in green leaves, and on one side a similar, though smaller, banner expressed a like wish for Mr. Davies Colley. All the decorations were, we believe, the entire work of the nurses and patients, and as such are deserving of great praise.

In Luke the decorations must have been the result of great taste and labour, both combining to make the ward look exceedingly pretty. A thin tracing of evergreen ran round the walls and head of the beds in the whole length of the ward, and over the beds were suspended the emblems of Faith, Hope, and Charity alternately.

The first thing noticed in entering is a large representation of the crest and motto of Mr. Cooper Forster placed at the end of the ward very neatly and accurately done, but what attracted the greatest attention were the caricatures drawn by "Our Special Artist." Our old friend, "The Actual Cautery" was there again, but had to give place to a worthy rival in the shape of a well executed drawing representing "A Circular Amputation." Father Christmas is the operator, a plum pudding, of substantial size, the patient, whilst around stand the dressers, two of whom, one as the clown, the other as pantaloon, seem to be firm believers in the Germ Theory of Septic Fever, for they are vigorously spraying over the pudding showers of Moët and Clicquôt, whilst a third dresser as harlequin and a facinating and fair sister as columbine approach with porringers and sponges.

The less frequented wards of Samaritan and Patience were also nicely decorated—and Inner Samaritan was not without the signs of festivity—indeed we were told, though we cannot vouch for the accuracy of the statement, that Nurse Coleman was seen with a piece of Mistletoe stuck jauntily in her cap.

GUY'S GLEE CLUB.

The Annual Concert of the Guy's Glee Club was given in the Governors' Court Room, on Wednesday Evening, Dec. 20th. Owing to the inclemency of the weather the audience was not so numerous as was expected. The Programme opened with the "Hunter's Farewell," by Mendelssohn, and was very creditably rendered, taking into consideration the great lightness required in singing it. A duet, by A. P. Lungley and J. H. Poland, followed next, called "Ladies fly from Love's smooth tale," but both singers being a trifle nervous, it lacked spirit. J. H. Poland then gave "The Raft," by Pinsuti, which, although rather too long, was well suited to his voice, the recitative parts being well sustained. The "Turkish Drinking Song" followed, and was sung with great spirit, the second Tenors performing their rather difficult part exceedingly well. T. B. Cross then played a Solo on the Piano, bnt the piece, "O, Steer my Bark!" did not show to advantage his powers of execution. A very difficult Part Song "The Beleaguered," by Arthur Sullivan, was well rendered, the marks of expression being especially noticed. A Solo, "Eily, Mavourneen," was sung with much feeling by R. S. Taylor, but his voice was not in good order owing to his exertions beforehand; he was, however, received with much app ause. A Trio, "I Naviganti," by R. S. Taylor, W. G. Gray, and H. Bates followed and was well calculated to show the flexibility of their voices. The "Huntsman's Chorus," from Der Freychutz, brought the first part of the Programme to a close. The Chorus was sung with plenty of swing and dash, the first Tenors maintaining their high notes with great vigour. After an interval of twenty minutes the second part was commenced with the old and well known Glee "Mynheer Vandunck," this obtained an encore, although it had only been practised by the Glee Club three times. A very pretty song, "Dresden China," was well sung by W. G. Gray, but was, we think, a little too light for his voice. The "Druids' Chorus," from Norma, followed, the solo part being sung by J. H. Poland; the symphony preceding it was exceedingly well played by G. F. Crooke, who throughout accompanied the glees excellently. A Solo on the Piano by T. P. Cross, called "Blue Bells of Scotland," was magnificently played, the touch and execution of the performer being especially admired; an enthusiastic encore was demanded and "Lysis" given. Next came the piéce de resistance of the evening, the chorus from Œdipus Rex, "Thou comest here to the Land." This play of Sophocles has been set to music by Mendelssohn, and has only been performed once in this country, at the Crystal Palace last year. The chorus, above mentioned, is perhaps one of the grandest that has ever been written, it is abounding in melodious harmonies,

though for the most part is in unison. Great care had been bestowed upon it by the Conductor of the Glee Club, and its performance fully repaid the attention given it. The Club must certainly be congratulated for the able manner in which they sung it, although the meagre applause that followed was not very encouraging. H. L. Bates next sang "My Queen," by Blumenthal, and with such good effect that he obtained a hearty encore. The "Bridal Chorus," from Lucia di Lammemoor followed, the solo part being given by W. G. Gray; the catching melody of the chorus seemed to please the audience. The well known duet, "Alls Well," was well rendered by R. S. Taylor and H. L. Bates, and great credit must be given to them, as owing to some mistake they were obliged to sing a duet, unknown to them, at a moment's notice. A "good night" song, composed by J. H. Poland expressly for the Glee Club, concluded the Programme, and shewed that the Composer was well versed in the theory and harmonies of music. Great praise is due to R. S. Taylor, as Conductor, for the efficient manner in which he led his choir, and also to G. F. Crooke, the Pianist. We are afraid that the Glee Club does not receive as much support from the authorities as it deserves. The members of the Club give up part of their time, with no little inconvenience to themselves, in order to increase the amount of the Samaritan Fund, and therefore we think that they ought to be encouraged in their endeavours to please others, and besides, what other art does so much to refine the mind and so fit young men for their duties in after life, in their profession, as music?

THE CONCERT.

The Annual Concert in aid of the Samaritan Fund, was given by the Glee Club on Wednesday, Dec. 30th, and considered as an amateur performance was a decided success. The weather was however very pardonable, and no doubt prevented many attending. The number of members has increased, and they told well in the Glees which were all rendered with good effect, the voices keeping well together, the vocalists being well supported at the piano by Mr. CROOKE, whose excellent time added considerably to the success. Amongst the Glees the "Turkish drinking song," and "Mynheer Vandunk," were particularly well rendered under the leadership of Mr. STANLEY TAYLOR. The choruses were also good, Mr. POLAND taking the solo in "Hasten, ye Druids," and Mr. GRAY in the "Bridal chorus," there were also two duets, one "Ladies, fly from love's smooth tale," by Messrs. LANGLEY and POLAND and the other "Army and Navy," by Messrs TAYLOR and BOLTS, both of which were rendered with good effect. Mr. POLAND'S "Raft," was sung with great feeling, and well deserved the encore. Mr. BATES was also encored after "My Queen," a song of some difficulty which he handled well. Mr. STANLEY TAYLOR rendered "Eily, Mavourneen" well, a song which suits his high and soft voice. "Dresden China," a quaint little song describing the musings of one, contemplating two little china figures, was well given by Mr. GRAY.

Mr. T. B. CROSS's two pianoforte solos "O, steer my bark," and "Blue Bells," were uncommonly well executed with his usual good style and touch, he was loudly encored after the latter, and responded with an equally pretty piece in good style.

The last glee "Good Night," the music of which has been composed by Mr. POLAND, and which he played himself, formed an appropriate termination to a very pleasant concert.

The Club are certainly to be congratulated in the manifest improvement since last year, and it is to be regretted that more were not present to enjoy the entertainment, the room was about two thirds filled, and all seemed well repaid for "braving the elements," and left well pleased.

The Samaritan Fund receives annually a good addition to its store, by the proceeds of the concert which was this year patronised not only by the Treasurer, but also by his predecessor Mr. TURNER.

It is pleasing to see that this, one of the old institutions at Guy's, is still kept up, as it must cost considerable time and trouble and necessitate much practice, but fortunately for the Fund there are always found those who are willing to give some of their time to benefit others in this way, the patients also reap the benefit of the kindness of the Club, for to them is given a concert in the out-patient's room on the night preceding the one described, which adds greatly to their Christmas enjoyments.

Football.

GUY'S v. BART'S.

This match was played at Blackheath, on Tuesday, Nov. 21st, and ended in a victory for Guy's by three goals, three tries to nothing. Tries were obtained by Stokes, two; Maclean, two; Pink, one; Jackson, one. Gordon kicked three goals.

Guy's.—A. W. Pearson, R. E. Morse (backs), L. Stokes (threerquarter-back), W. Gordon, F. Maclean (half-backs), P. F. Gilbert (Capt.), T. A. I. Howell, R. S. Taylor, C. Pink, F. S. Wilkinson, D. D. Roberts, J. Rees, J. Reader, A. H. Jackson H. Liddell (forwards).

GUY'S v. HARLEQUINS.

Played at Blackheath, on Saturday, November 25th. After an hour's play the game resulted in an even draw, no score being made by either side. Gilbert and Maclean play well for Guy's; Perham and Oswald for the Harlequins.

Guy's.—Q. R. Veitch, R. E. Morse (backs), H. Shepherd (three-quarter-back). A. H. Jackson, F. Maclean (half-backs), P. F. Gilbert (Capt.), T. A. I. Howell, R. S. Taylor, F. S. Wilkinson, H. Liddell, J. Rees, J. Reader, D. D. Roberts, F. Mansell, H. Lister.

Harlequins.—C. Bassano, A. Grant (backs), W. Bassano (three-quarter-back), J. Stivin, G. W. Perham (half-backs), P. C. Oswald, H. Burnaud, R. Manley, — Tillyer, J. Gow, A. Price, C. E. Mussman.

GUY'S v. NAVAL COLLEGE, GREENWICH.

This match was played at Greenwich, on Wednesday, December 13th, and ended in an easy victory for Guy's by six goals, three tries, and numerous touchdowns to nothing. Pearson kicked four goals; Stokes and Gordon each dropped one. Tries were obtained by Jackson, three; Stokes, Boswell, Maclean, and Gordon, one each.

Guy's.—A. W. Pearson, Q. R. Veitch (backs), L. Stokes, (three-quarter-back), F. Maclean, W. Gordon (half-backs), P. F. Gilbert (Capt.), J. A. Fraser, T. A. I. Howell, C. Pink, F. S. Wilkinson, A. H. Jackson, D. D. Roberts, H. Liddell, J. Reader, — Boswell.

Naval College.—Onslow (Capt., three-quarter-back), Bishop, Gaitskill (backs), Bain, Bush (half-backs), Pae, Stebbing, Rawson, Hewettson, Smith, Bairnsfuther, M'Donald, Orford, Fisher, Wroughton (forwards).

GUY'S HOSPITAL v. BECKENHAM.

The above match was played at Blackheath on December 16th, and resulted in favour of Guy's by two goals and one try to nothing. Howell obtained two tries and Shepherd one. Veitch and Jackson each kicked a goal.

Guy's.—T. A. I. Howell (Capt.), A. H. Jackson (half-backs), Q. R. Veitch, R. E. Morse (backs), H. Shepherd (three-quarter-back), F. S. Wilkinson, D. D. Roberts, H. Liddell. C. Collins, A. Taunton, A. Pierson, A. Milligan, G. R. Green, B. Whyte (forwards).

Beckenham.—C. E. Freeman (Capt., three-quarter-back), F. W. Freeman, — Smith (half-backs), Murray Duff, Booth (back), C. N. Butler, J. Irwin, C. Rohde, P. Hearne, E. MacKeen, — Mansfield, — Fletcher, — Topp, — Burrows, Clark, Kennedy (forwards).

UNITED HOSPITALS FOOTBALL CLUB.

This Club journeyed to Liverpool to play a match with the Liverpool Football Club on Monday, December 4th, but were most unfortunate in the weather, as nothing could have been more gloomy or miserable, an incessant rain falling nearly the whole time they were absent from London; but in spite of this a most enjoyable and vigorous game took place, in the presence of a good number of enthusiasts, which resulted in a draw, considerably in favour of the Hospitals, by six touchdowns to one. The ground was so wet that running was almost an impossibility, and had the day been fine the united team would probably have scored more decisively, as their kicking was far superior to the northerners. The visitors were most hospitably entertained at dinner after the match, and a very enjoyable evening was passed, there being plenty of melody and speeches.

Next day the team went on to Leeds to try conclusions with the Leeds Club, and succeeded in getting the best of it, the game, after an hour and ten minutes hard play, being drawn in their favour by five touches to two. The United, unfortunately, had to play one short, as Power was slightly injured at Liverpool. The ground was worse than on the previons day. and whether it was the effects of travelling, or of the previous night's entertainment, it was evident that the Medicals were somewhat stale, and certainly had these little impediments been absent, would have scored more heavily. The rival teams dined together a terwards, and on the following morning the United Hospitals Football Club returned to town, every one, apparently, having enjoyed the trip very much. The United Hospital team was as follows:—

P. F. Gilbert (Capt.), T. A. I. Howell (Guy's), E. A. Hunt, T. H. Helleby (St. George's), E. Landon, T. R. Lunn, L. Houghton (St. Thomas's), E. J. Power (St. Bart's.), B. J. Newmarch (King's), J. M. Biggs (University), forwards; A. W. Pearson (Guys), and W. W. Francis (University), backs; L. Stokes (Guy's) three-quarter-back; W. E. Collins and H. B. MacKay (St. George's), half-backs.

GUY'S HOSPITAL II. v. ST. GEORGE'S HOSPITAL II.

This match was played on Thursday, December 14th, at Blackheath, and after a hard fought game resulted in a victory for Guy's by a goal and a touchdown to nothing. After half-time was called the ball was thrown out of touch near St. George's goal, and Liddell getting hold of the ball ran in; the try was converted into a goal by Veitch. The back play of Guy's was decidedly superior, but at times the St. George's forwards pressed their opponents hard. For St. George's H. P. Dimmock, H. Lee, F. C. Hawkins, and A. W. Shettle were conspicuous; and for Guy's, Jackson, Liddell and Veitch played well.

Guy's.—Green (Capt.) Boswell, Atkinson; Milligan, Taunton, Chubb, Pierson, Burrows, Starling, Lawson, Jackson and Liddell (half-backs), Shepherd (three-quarter-back), Veitch and Fasken (backs).

St. George's.—H. P. Dimmock, H. Lee, H. W. Hubbard, F. C. Hawkins, N. M. Reid, L. W. Swabey, S. W. Vasey, E. M. Wilson. E. F. Smith, H. W. Shettle, W. H. Young (Capt.), (half-backs), E. B. Smith (three-quarter-back), H. C. Hallowes, F. Holton (backs).

NEW BOOKS.

A "Manual of Physiology" by Prof. Küss appears to be just the kind of book one can cordially recommend to men who may lack time or inclination to toil through the pages of a complete treatise, though they cannot content themselves with the superficial knowledge to be gleaned from the more elementary works. To such students this little book will prove most welcome. By a judicious arrangement of the plan of the work and by keeping well to his text the author has contrived to compress into a little more than five hundred pages not only a clear exposition of the facts of Physiological Science but also such illustrations as will serve to impress them on the memory. His style is not ornate but concise and clear: the chapter on Embryology being especially good. The illustrations are carefully drawn and, what is even more important, many of them are new and original, moreover the type and paper are quite equal to Messrs. Bailiere & Co's standard.

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This unpretending little volume contains an enormous amount of Anatomical information condensed in sixty four pages of text, and will prove a valuable aid to many a student up for an examination who wishes to refresh his memory on some easily-forgotten points. The first part treats of the regions or spaces described in the books giving in a tabular form their boundaries and contents, structures underlying important muscles, &c., while the second part describes some of the most difficult nerves and ganglia with their branches and relations. Anyone who intends to keep up his regional Anatomy will find this little book useful, and we hope the author will keep his promise to issue more of the same series.

"Aids to Botany" is a similar work, elementary, yet containing much information, and well adapted, we should say, for the Hall Examinations.

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"Aids to Anatomy, by George Brown, M.R.C.S,, L.S.A., late Demonstrator of Anatomy at Westminster Hospital Medical School." Balliere, Tindall & Cox.

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PRIMARY EXAMINATION PAPERS,

Set December 13th, 1876.

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2.—What are the Oxygen compounds of Phosphorus? Give the tests for Phosphates.

3.—Describe the composition of fats and oils, and the process of saponification.

4.—Give the preparation of Hydrocyanic Acid, with the reactions that occur.

MATERIA MEDICA.

1.—Describe the N. O. Umbelliferœ, and emunerate the officinal plants in it.

2.—What are the Gums and Gum Resins? Give the tests for their purity.

3.—Enumerate the officinal preparations of Lime; say how they are directed to be made. Give their doses.

We acknowledge with thanks the receipt of £1 from Mr. Bryant, aud 10/6 from Dr. Stevenson, as their subscription to the "Gazette."

UNIVERSITY OF CAMBRIDGE.

On 13th December, Mr. E. Amphlett, M.A., St. Peter's College, read a Thesis upon Insular Sclerosis and Paralysis Agitans, and proceeded to the Degree of M.B., on the following day.

"THE SHADOW OF THE END."

It was on a Tuesday, I was particularly impressed with the appearance of John Donovan. He was a quartermaster, aged 34, of short stature, but rather thick set; his hair was dark, and his features swarthy and severe. He was dressed in his suit of oilskins (for it was wet) and was going up on deck. Formerly he had suffered much from rheumatism in the shoulder, and on one occasion he had sustained a severe injury in the boat muster, compelling him to remain at home during that voyage; but of late he had not complained of any ailment. The expression of his face was always fixed and grave, though calm and quiet, but now it was unusually sad and solemn, and almost gloomy, as if he may have had himself some presentiment of his fate. Or was it that the state of abstraction which not unfrequently manifested itself in his countenance, may have participated in the causes of his accident? But a rainy day is often sufficient to damp anybody's spirit. On the Thursday he was *dead*. He had fallen from the crane line of the mizen starboard backstay, which had given way as he stood upon it. Probably he was taken by surprise and lost the hold he should have had upon the stay itself. The height was 40 feet, and he fell with such violence that a portion of the frontal bone was driven half an inch into the pine wood deck. He was taken to the Hudson City Hospital and died within an hour. We may say of him, as of many others, "Boldly below he did his duty; and now he is gone aloft."

Perhaps it was only a coincidence this "shadow of the end," as it has been called, and his untimely death. For my own part, I may frankly say that although I was at the time especially struck with his countenance, I did not interpret its peculiarity till afterwards. I have seen it elsewhere in some who died from disease. It has been remarked, Miss Braddon says, in some great heroines (*e.g.* Jane Grey, Mary Stuart, Marie Antoinette, Charlotte Corday). But if so in the case of these, in how many more who lived even a tranquil life and died in a good old age? We should be wrong, I believe utterly wrong, were we to attribute it to presentiment or to the finger of fate. I believe it to be a mark of Resignation or Submission; resignation to the consequences of the performances of one's persuasions, as if it were written on their countenances. "Theirs not to make reply; theirs but to do and die;" as though they were possessed indeed of the power of doing their duty, or what they considered their duty, regardless of the consequences, but devoid of the faculty of resisting its results; endowed with such a concentration of energy, or what Lord Lytton might have called Vrill-force, as would enable them to compass or to effect the crowning action of their lives, even at such a peril, but destitute or regardless of the means of self preservation or of self protection.

We believe that, in disease, there is always some condition of the body, or its parts, which renders it more or less susceptible to morbid influences. Possibly this may sometimes find some expression in the face, some look of submission, some want of resistance, some loss of Vrill-opposition not only to the advent of disease but also to its encroachment upon the "spring of life;" and none the less to the surprise of accidents. "While there is life, there is hope" is true enough; but "while there is hope, there is life," though apparently a paradox, may serve to illustrate my meaning.

Oct. 20th, 1876. I. R. S.

A CASE OF HYDRONEPHROSIS.

John F., æt. 14, was admitted into No. 30 Accident, under Mr. HOWSE, on August 30th. He had been sitting on the front part of a four-wheeled waggon containing 2 tons of coal, when the waggon turning sharply round a corner he was thrown off on his face and one of the front wheels passed over his body. When picked up he was frothing at the mouth but no blood was visible anywhere.

When brought to the hospital the boy was in a semi-collapsed state with Temperature 97·2 and Pulse 100. The left crest of the ilium was fractured. His urine was drawn off but no blood was found in it.

On Sept. 1st, Temperature was 99·4.

On the 2nd, Temp. 98·8, Pulse 100. Face rather flushed, tongue dry, lies on back with thigh slighty flexed, considerable discolorations of abdomen, and much fullness and tenderness in iliac and lumber regions.

On the 12th, there was a fluctuating swelling on back part of right lumbar region. Not so much pain about part as there had been.

The tumour continued to get larger but on the 19th it had diminished in size considerably, the temperature continued about normal.

On the 23rd the swelling was much larger and very painful.

On the 28th the boy was put under chloroform, and the tumour was punctured with a trocar and cannula and 30 oz. of fluid having the smell and appearances of urine were withdrawn.

Two days afterwards, 30th, the tumour had reappeared, and on October 2nd it was very much larger, not very painful and had a livid appearance.

On October 6th, Dr. TAYLOR examined it and reported—In the right flank is an almost hemispherical tumour, projecting laterally, measuring about 4 in. from above downwards, and 4 in. from before backwards, projecting from 2 to 3 in. from the general level. It is very tense and fluctuates; in the right side of the abdomen can be felt resistance, which reaches as far as the middle line, and extends downwards to about the level of the crest of the ilium. Its outline can be distinctly recognised above near the ensiform cartilage, elsewhere it is less distinct. Fluctuation is communicated from it to the tumour, the surface is mostly dull but there is resonance from 1½ in. to 2 inches from the umbilicus gradually becoming fainter. There is no line of resonance indicating that the colon, apart from the other intestines, lies in front of the tumour. The base of the right lung is dull, and the air enters badly. The impulse of the heart is in the 4th interspace, a little above the nipple. The seat of puncture on September 28th is about the centre of tumour prominence.

At 2 p. m., the tumour was punctured with the aspirator needle, about ½ in. below former puncture.

After the fluid had flowed freely for some time the aspirator was applied, and more fluid withdrawn. After the removal of the cannula, the right flank was sunken, the whole of the right side was resonant from the middle to the lateral line, and no hardness or resistance could be perceived here.

The fluid drawn off measured 2 pints 12 oz., contained a large quantity of albumen, and had the odour and appearances of urine as before.

On the 10th, the swelling was again increasing in size and on the 15th, it was punctured with a trocar and cannula and 2 pints of fluid resembling the last were removed.

After this the tumour again began to appear, and the boy complained of so much pain that ⅓ gr. of Morphia was administered hypodermically at night.

On the 21st, the swelling was 5½ inches in length, 3 in breadth, and 2½ above the surface. It was re-punctured on the next morning and 32 oz. of fluid withdrawn.

[We are indebted to Mr. TARRANT for the above.]

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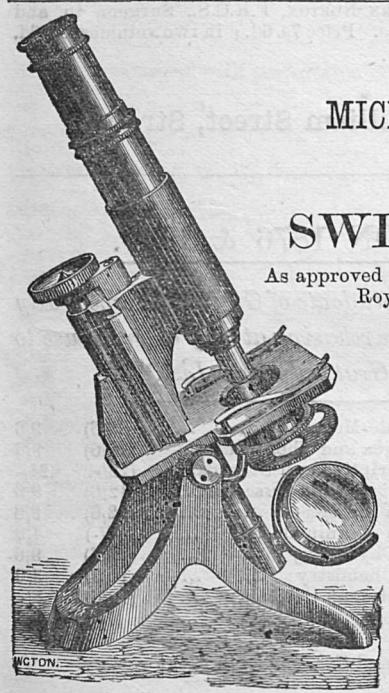

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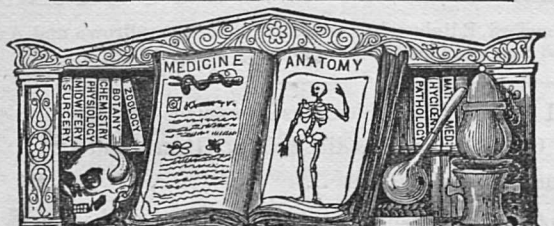

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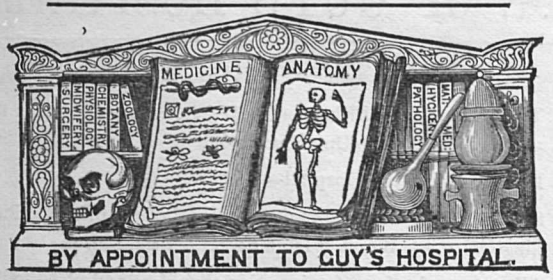

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Clinical Lecture.

By S. O. HABERSHON, M.D.

October 14th, 1876.

(Continued from page 3.)

The next case which I will bring before your notice is the following:—

W. D., æt. 33, admitted 6th October, 1876. Was a sailor till seven years ago, since which time he became a printer, and was accustomed to lift heavy weights of more than a hundredweight. Enjoyed good health until seven years ago, when he fell from the top of the mast about 62 feet, fracturing both thighs and the lower jaw. Does not know if he injured his chest, but bled from the mouth. Was in hospital abroad for ten months, after which he was discharged from the navy in consequence of his injury. Contracted gonorrhœa several times, never secondary symptoms. Since the injury enjoyed comparatively good health until about four years ago, when he had difficulty in breathing and suffered from palpitation. This caused him much distress and was accompanied by pains in the chest, varying in intensity and position. Has attended as out-patient at a dispensary for some weeks. Has lost much flesh. Has never suffered from rheumatic fever or swollen joints.

Patient is a tall, thin man; skin pale, eyes blue, nails inclined to curve, no œdema of feet or ankles. Prefers to lie on his back, breathing with some difficulty. Marked pulsation at root of neck. Pupils natural.

Chest somewhat flattened. A marked hollow near the sternum in all its length. Chest sounds normal as far as heard in front, but much masked by heart sounds; percussion note good. Behind the left base some slight moist sounds heard, very localized.

Heart impulse most plainly observed 2½ inches below and one inch to the outer side of the nipple. Pericardial dulness commences above at upper border of 4th rib, and extends laterally from the midsternal line to one inch to the left of the nipple.

Pulse, 80 per min., regular, rather incompressible, and equal on both wrists.

Heart sounds.—At the base of the heart the normal sounds are replaced by two blowing sounds conducted in the course of the aorta, but gradually decreasing towards the apex of the heart. At the apex the sounds resemble those at the base but are much weaker.

Abdomen retracted. Just to the right of the umbilicus a very marked pulsation, with slight expansive movements and a double bruit, is heard at this point.

Liver dulness does not extend below the level of the costal region.

Urine sp. gr. 1025; no albumen or sugar.

This patient was admitted in a state of urgent dyspnœa and distress, the heart's action was violent, the skin pressing, the sharp splashing pulse, murmurs heard over the heart, indicated an affection of the aortic valves, but there was no obstruction of the right of the heart. The liver was not enlarged, and the chief sign of distress was the difficulty in breathing.

It was doubtful whether he would survive many hours, but perfect quiet has allowed the heart to recover some power; to assist the overtaxed muscular energy ether was given as a stimulant. The patient is now composed, is able to lie down, but the dilatation of the heart and of the aorta continue, and the valves must always remain imperfect.

The next case I will allude to is as follows:—

J. P., æt. 37, sailmaker, admitted 26th September, 1876. Clinical ward 10. Enjoyed good health until 6 months ago. Has had venereal affections two or three times, never followed to the patient's knowledge by any eruption over the body, but he suffered from severe sore throat after each attack. Has never been a hard drinker, but has occasionally been worse for liquor when on shore after a voyage. (Here it may be observed that intemperance may greatly aggravate heart disease, though never seeming to produce direct valvular affection. Has never had rheumatic fever, nor does he ever remember to have been troubled with shortness of breath.

Twelve months ago he had an epileptiform fit in Hong Kong, and six months later the sight became bad and he began to squint. Three months ago ptosis came on suddenly, and the other symptoms increased.

On his admission he was taken in a fit suddenly—of epileptiform character, and lasting about half an hour. There is ptosis of both eyelids, but most of the left. Both eyes are turned outwards and cannot be moved inwards, upwards, or downwards, the 3rd nerve being thus shown to be paralysed, while the eye is turned outwards from the 6th nerve acting alone; both pupils are somewhat dilated, also owing to paralysis of the 3rd nerve; the sight is bad, especially in the left eye. Complains of numbness in the side of the face, from the 5th nerve also being partially paralysed.

In this case there is disease at the base of the brain of a syphilitic character affecting the origin of the roots of these two nerves, and which will in all probability be benefited by iodide of potassium; the paralysis is already greatly diminished. There is also heart disease, the aortic valves being affected, but no urgent distress or dyspnœa, the reason being that the dilatation is compensated for by the hypertrophy.

The following is another case of aortic imperfection:—

G. S., æt. 27, admitted 5th October, 1876, Clinical 13. A rocket-driver in an ammunition factory, very hard work, and work subjecting him to rapid changes of temperature. There is nothing special in his family history, both parents being alive and well; no history of rheumatism, gout, phthisis, or nervous disease in the family. Patient is a married man, his wife is healthy and he has two children healthy. He is the 7th of a family of 15, and has always been delicate, but with

the exception of suffering from small pox at the age of 3, enjoyed good health until the age of 18, when he first suffered from palpitation. Two years later he suffered from rheumatic fever, and during the attack blisters were applied to the cardiac region, probably indicating endocarditis. Since then he has always been subject to shortness of breath and palpitation of the heart. Has always been temperate.

Three weeks ago he was attacked with pains in his joints, and his feet began to swell. He attributes this attack to sudden exposure to cold when heated by his work. For the last fortnight he has been quite unable to lie down at night on account of the pain in the back between his shoulders.

Patient is a thin, pale man of fair complexion with sandy hair, about 5 ft. 5 in. in height. He lies propped up in bed, this being his easiest position. Eyes bright; pupils moderately dilated; conjunctiva yellowish; vessels distinct.

Chest well formed and moves freely during respiration. Anteriorly, there is good resonance all over both lungs, with the exception of that portion of the left chest where it is masked by the increased dulness of the heart. On auscultation, harsh and sonorous rhonchi are generally audible. Posteriorly at the bases the resonance is impaired, and at both bases there is much crepitation; the voice here and there is quite dronchophonic in character.

The heart dulness commences at the 3rd rib, but extends downwards and outwards for a considerable distance,—in fact merging into the splenic dulness. Heart's impulse is diffused and thumping, but is to be felt $2\frac{1}{4}$ inches to the outer side and one inch below the nipple. A double aortic bruit is audible all over the region of the heart, and a most distinct thrill is to be felt in the vessels of the neck, especially on the right side.

In this case hard work, and besides this the rheumatic fever, seem to have been the causes of his disease. He continued to work notwithstanding his disease, and thence dilatation resulted. He is considerably relieved, but the organic disease must persist.

Dr. HABERSHON then quoted another case in which aortic disease was brought on by hard work, in a woman, which might therefore be looked upon as an exceptional occurrence. She suffered from urgent distress, which she attempted to relieve by taking ardent spirits. With regard to alcohol it might be said, that, though it may relieve for a time. it does harm in the end by increasing engorgement of the liver.

He then alluded to a case of mitral disease with enlargement of the liver, albuminous urine, ascites, and contrasted it with the above cases, explaining how from the blood being thrown back on the liver and kidneys, ascites and albuminuria resulted. The former instances, those of aortic imperfection with dilatation and hypertrophy, being relieved by absolute rest, and by the removal of everything that would strain the action of the heart, the latter, mitral disease, by free action of the bowels by diuretic medicines, and the judicious use of alteratives with digitalis.

Clinical Surgery.

GASTROSTOMY. By Mr. BRYANT.

Gastrostomy, which signifies the making of a mouth to the stomach, is not to be confounded with the operation of gastrotomy, which is merely the opening of the stomach for the purpose of extracting foreign bodies, &c.

The operation shortly described is as follows:—Make an oblique incision 3 or 4 inches long, commencing at the linea semilunaris on the left side just under the margin of the ribs, the object being to find the cardiac end of the stomach; the viscus being held by the finger and thumb, a double silk ligature is passed through its walls, and another about $\frac{3}{4}$ of an inch lower down; the stomach is then fastened to the edges of the wound just in the same way as the intestine is in the operation of colotomy, the two ends of the double ligature may be tied over two pieces of bougie, one introduced against the inner surface of the stomach, and the other upon the integument; by this means the thin walls of the stomach are kept in close contact with the skin.

Two cases where Mr. BRYANT performed gastrostomy were then detailed.

CASE 1.

Thomas G., an intemperate man, æt. 48, admitted under Dr. HABERSHON, October 1st, 1866. History of syphilis when 20 years of age. Four months before admission he had sore throat, which rapidly became worse, so that he was soon unable to take solid food. During these four months he lost 28 lbs. in weight.

On admission.—He was much emaciated and pale, his voice feeble, and his breath offensive. Any attempt to swallow caused great pain, and in making it the food was constantly and at once ejected through the nose and mouth. The finger passed into the pharynx detected a hard swelling in the larynx. He was fed by nutrient enemata for a few days, but, as the enemata began to be returned, and swallowing was still impossible, the operation of gastrostomy was performed by Mr. BRYANT, chloroform being given. No difficulty was experienced during the operation. No food was introduced into the stomach for 24 hours, but enemata were used instead. Next day milk and eggs in a mixture were given through artificial opening, and the man appeared to rally, but progress was not steady. On the fourth day he became delirious, and on the sixth day he sank, having survived the operation 130 hours.

Post-mortem examination showed the stomach well in contact with edges of wound, and no signs whatever of peritonitis. Almost a complete ring of ulceration

with a hard base surrounded the œsophagus at level of cricoid cartilage. Extensive phthisical cavities occupied apex of right lung, while its lower $\frac{2}{3}$ were in a state of red and grey hepatization; the left lung also contained two softening patches. The cause of death in this case was then pneumonia.

CASE 2.

Joseph C., æt. 53, had kept beer shop and drunk freely. Had quinsy badly $3\frac{1}{2}$ years before, and $2\frac{1}{2}$ years after had severe attack of sciatica, and at same time noticed a constriction in his throat which interfered with his swallowing. For 40 weeks before admission he had not taken solid food.

On admission.—He was very thin and looked ill; a lump, tender on pressure, could be felt at left side of trachea just below thyroid cartilage, but no growth could be seen on looking into the throat. He was troubled with a cough, but had no power to expectorate; he often spat up dirty-coloured mucous, frothy, and streaked with blood. As he could not swallow and enemata were returned, gastrostomy was performed by Mr. BRYANT. On opening the peritoneal sac some distended intestine appeared through the wound, but was easily pushed aside, and the cardiac end of stomach caught. Man never thoroughly rallied, but died 20 hours after operation from bronchitis, he having no power to expectorate and his face becoming purple.

P.M.—Showed broncho-pneumonia of both lungs, mucous and pus flowed in sections. Œsophagus showed an ulcerated path just below level of glottis, which had narrowed the tube very much, and also a large mass of secondary cancer almost filled the œsophagus about 4 inches from its stomach end. No peritonitis about wound.

Remarks.—In the first place, the operation is a right and perfectly justifiable one. It has been performed 24 times, the last case being one of M. Vernonil, of Paris, which was done last July, the patient being now alive and well. This was the first case in which the operation had been done for simple cicatricial stricture following the swallowing of caustic potash. In all the other cases it was done for cancer, Mr. Sydney Jones' case surviving for 40 days. Operation should not be delayed till patient is brought as it were to death's door by starvatiou, but the following rule was laid down:—In all cases of dysphagia, from whatever cause arising, the question of gastrostomy ought to be considered as soon as the patient becomes unable to take solid food. Dangers of the operation are not so great as they have been made out to be; we are now not so frightened at the peritoneum, we have only to think how roughly we are obliged to deal sometimes with that membrance in ovariotomy, and yet a good result follows, hence there is no fear from peritonitis. Results of gastrostomy ought to be as good as the results obtained from colotomy when performed for stricture of rectum, for almost the identical conditions are present in both cases.

CASE OF IMPALEMENT WITH PERFORATION OF RECTUM & BLADDER.

COMPLETE RECOVERY. UNDER MR. BRYANT.

A. W. æt. 12 years, was admitted under Mr. BRYANT October 12th, 1876. About an hour previous to admission he fell from a tree upon a spike of some area railing, the spike running into the buttock.

When first seen the boy was partially collapsed, and complained of great pain from rectum to umbilicus.

There was an incised wound on right buttock immediately internal to tuber ischii about an inch long and about two inches from anus. A probe passed through wound could be felt at rectum. There was also hæmorrhage from rectum. When examined some hours later by Mr. BRYANT a ragged wound was found about three inches up in posterior wall of rectum, and another probably communicating with the bladder, just behind prostate. Blood and urine have passed per urethram. The boy was placed under chloroform, and when sat up a quantity of fluid and fæces gravitated out, supposed to be from peritoneal cavity. Mr. BRYANT then opened the bladder as in the lateral lithotomy operation to allow free escape of urine.

At 3 a.m. he had considerable pain in abdomen, which was painful and tympanitic on percussion. A little delirious. ℞ Tr. Opii ℥. v. 4tis horis. He lost a large quantity of blood since the operation. Milk diet.

October 13th.—Morning temperature, 99°. Pulse, 96. No hæmorrhage; less pain. Evening: pain in abdomen worse, but relieved by hot fomentations. Skin hot, cheeks flushed, tongue furred, fungiform papillæ prominent.

October 14th.—Morning temperature, 100°. Pulse, 108. Considerable pain in rectum, and down left leg. Evening: bowels moved with great pain, has passed flatus with urine and loose fæces. ℞ morph gr. 1/6 sub cute inj.

October 15th.—Temperature, 98°. Pulse, 90. Urine passes into bed per rectum and perineal wound. Original wound covered with creamy pus.

October 16th.—Temperature, 99°. Pulse 96. Abdomen still tender, has great desire to micturate. In the afternoon Mr. BRYANT passed a catheter.

October 17th.—Temperature, 99. Pulse, 84. Was in great pain during the night, relieved by hot fomentations. Ordered bread and milk.

October 18th.—Temperature, 91°. Pulse, 80. Great pain in rectum and hypogastrium. Tongue furred.

October 19th.—Temperature, 99°. Pulse, 71. Great pain in rectum and perineum. Urine passes per rectum, very little by perineal wound, and more by penis.

October 20th.—Temperature, 99°. Pulse, 84. Original wound nearly healed. Tongue cleaning. ℞ morphiæ acet gr. $\frac{1}{4}$ sut cute omni nocte.

October 21st.—Temperature, 98°. Pulse, 78. Bowels moved three times during the night. a little urine passed naturally.

October 23.—Bowels moved yesterday, and twice to-day, with great pain. Urine passes per urethram occasionally; a little per rectum. R. Poppy head fomentations. Tr. Opii ♏ x. every four hours. In great pain; peristaltic action of the intestines perceptible through the walls of abdomen. Abdomen painful and tynpantic. Temperature, 98-4°.

October 24th.—Temperature, 99-4°. Pulse, 84. Bowels very relaxed during the night. ℞ warm water enema. Abdomen still distended and painful.

October 25th.—Temperature, 99-4°. Pulse, 84. In less pain.

October 28th.—Has been improving. *All* urine passes now per urethram. Wounds healing.

October 31st.—Bowels have not acted for five days; relieved by a dose of œ Ricini. Ordered chicken. Temperature, 98-1°.

November 3rd.—Both wounds, original and perineal, nearly healed.

November 6th.—Has been in great pain again. Improving. Bowels not open. Œ Ricini ½ oz. statim.

November 7th.—Improved.

November 9th.—Incontinence of urine noticed, which however passed off in a few days. He progressed favourably from this time, and was discharged well November 20th, 1876.

(We are indebted to Mr. C. K. SHAW for the above.)

TANNIC AND GALLIC ACIDS.

The Quercus Infectoriæ, which produces those excrescences called galls or nut-galls, is a small tree or shrub from 4 to 8 feet high, inhabiting Asia Minor, from the Bosphorus to Syria, and from the Archipelago to the frontiers of Persia. On the sides and at the ends of the branches and shoots of this tree the female of the insect Diplolepis Gallæ Tinctoriæ makes a puncture with her ovipositor, and deposits her ova. An excrescence or gall is soon formed, within which the larva is developed. As soon as the perfect insect is produced, it eats its way out. If those galls are examined, from which the insect has escaped, there is observed, externally, a circular hole leading to a small canal, which passes to the centre of the gall. In those galls in which the pupa state has not been put off there is no external hole nor an internal canal. Aleppo galls are the best commercial variety, and contain from 25 to 65 per cent. of Tannic Acid. This substance is a glucoside, that is, a proximate vegetable principle, which, by ebullition with dilute acid or other method of decomposition, takes up the elements of water, and yields glucose accompanied by a second substance, which differs in each case according to the body operated upon.

Tannic Acid, when boiled with diluted sulphuric acid, is resolved into Galiic Acid and glucose. The method given in the Pharmacopœia is to place powdered galls moistened with water in a warm place for five or six weeks, occasionally re-moistening; fermentation occurs, and impure Gallic Acid is formed. The product is treated with about three times its weight of water, boiled, to dissolve the Gallic Acid, filtered, the solution set aside to cool, deposited Gallic Acid collected, drained, pressed between folds of paper to remove all mother liquor, and, if necessary, purified by re-crystallisation from water, or by solution in hot water and treatment with animal charcoal, which absorbs colouring matter. On filtering and cooling most of the acid separated in the form of fawn-coloured slender acicular crystals.

The nature of the reaction by which Gallic Acid is thus produced is probably similar to that of the action of dilute acids on Tannic Acid, during the process oxygen is absorbed and carbonic acid gas evolved, the sugar being broken up or perhaps prevented from being formed.

Tannic Acid is obtained from galls by exposing the powder to a damp atmosphere for two or three days, and afterwards adding sufficient æther to form a soft paste. After allowing this to stand for twenty-four hours in a well closed vessel, it is enveloped in a linen cloth, submitted to a strong pressure, so as to separate the liquid portion which contains the bulk of the tannin in solution. The pressed cake is reduced to powder, mixed with sufficient æther, to which one-sixteenth of its bulk of water has been added, to form again a soft paste, and pressed as before. The expressed liquids are mixed, exposed to spontaneous evaporation until, by the aid subsequently of a little heat, it has acquired the consistence of a soft extract. It is then placed on earthen plates and dried in a hot-air chamber at a temperature not exceeding 212° F. Conflicting statements have been made with reference to the action of æther in extracting Tannic Acid from galls. The thick syrupy liquid obtained when galls are treated with washed æther has been sometimes represented as a solution of Tannic Acid in æther, and at other times as a solution of the acid in the water separated from the washed æther. In support of the latter statement, reference has been made to the fact that the liquid obtained by percolation or expression often forms two strata, the upper one consisting of æther with very little Tannic Acid, while the lower one has been described as a strong solution of the acid in water. Tannic Acid is readily soluble in water and rectified spirit, very sparingly in pure æther, though soluble in common æther (which contains alcohol) when the æther is saturated with water.

Tannic and Gallic Acids are most important medicinal substances possessing a powerful astringent action. Tannic Acid is usually employed for direct local application, and Gallic Acid where the bleeding vessels have to be reached by means of the circulation. The therapeutic action of galls is owing to the contained Tannic and Gallic Acids—the latter about 5 per cent. Tannic Acid is very soluble in water; a solution to be used as a styptic may be made 10 in 8. It is soluble to the same extent in Sp. Vini Rect. In glycerine 1 in 3, or by heat 1 in 2. Olive oil is also a solvent. The Pharmacopœia preparations of Tannic Acid are the Glycerine, containing by measure 1 in 4½; Suppository, 3 grains; Suppository with soap, also 3 grains; and Troschisci, ½ grain each. On account of its great solubility in water and other fluids Tannic Acid presents no difficulty for administration in a liquid form. It has a very astringent, unpleasant taste, and on this account it is usually given in the form of pill. Glycerine is the best excipient for Tannic Acid—five grains of which may be made into a medium sized pill with one minim of glycerine. Gallic Acid is more frequently administered internally than Tannin; it is very insoluble compared to the latter substance. Its solubility in cold water is 1 in 100, a little over 4 grains to ℥j. It is much more soluble in hot water. A very common method of prescribing Gallic Acid is in powders, to be dissolved in a little warm water before administration. When this acid is ordered in a mixture, it is better to give mucilage with it, so as to cause a more durable suspension. Rectified spirit dissolved the acid to the extent of 1 in 8, and this solution mixed with water in any proportion without separation. Glycerin Acid Gallic is a satuated solution containing about 14 grains of acid in ℥j.; when mixed with water the acid slowly separated. A mixture containing Glycerin Acid

Gallic 3j. Agad 3j. is perfectly clear for a short time after mixing, but in the course of a few hours the deposited acid forms a hard cake at the bottom of the bottle, which it is extremely difficult to detach. Glycerine but very slightly aids the solution of Gallic Acid in water. This acid may also be made into a pill with glycerine, but they are not so easily made as those of Tannin and are larger. A mucilage of tragacanth and glycerine is a better excipient.

Tannic Acid, or a variety of it, is widely diffused through the vegetable materia medica. Cortex Quercus owes its medicinal value to this acid. Bael fruit (the fruit of Ogle Marmelos) is said to owe its power as a remedy for dysentery and diarrhœa to a variety of Tannic Acid. The astringency of Pomegranate-root Bark (*Pumica Granatum*) is due to a tannic acid—its anthelmintic properties probably to a resinoid matter. The same may be said of Logwood, the colour of which is due to oxidised Hæmatoxylin. Rhatany Root contains about 20 per cent, of Tannic Acid, its active astringent principle. Radix Rhei about 9 per cent. Bearberry leaves owe most of their therapeutic action to about 35 per cent. of Tannin. Catechu, Kino, and Elm Bark contain a variety of Tannic Acid termed Mimotannic Acid, which gives a greenish precipitate with neutral solutions of ferric salts. Larch Bark, now contained in the appendix to the Pharmacopœia, contains a considerable quantity of Tannic Acid, giving olive-green precipitated with salts of iron.

NOTES OF THE MONTH.

ROYAL COLLEGE OF SURGEONS.

Pass Examination for the Membership, January, 1877.

The following Guy's men passed in Surgery only:—Messrs. Mansell, L.S.A.; John Mackern; Gardener; Morgan, L.S.A.; Turner, L.S.A.; Hunt, L.R.C.P.; Roberts, L.S.A.

Obtained the Diploma: Messrs. Creed, Tarrant, Malpas, F. B. Maclean, Liddell, Clowes, Perry, Bunny.

The following papers were set:

SURGERY.

1.—Describe anatomical relations of last four inches of the Rectum in the male, its structure, and the management of its blood vessels.

2.—Mention, in order, the parts which would be divided in amputating through the knee joint.

3.—A man has a penetrating wound of the chest and lungs; mention the complications that may arise in the progress of the case, and the treatment you would adopt.

4.—What are the symptoms, progress, and results of gonorrhœal ophthalmia in the adult? Describe the appropriate treatment.

5.—Describe acute inflammation of bone in youth, its symptoms, pathology, and treatment.

6.—Mention the varieties of urinary calculus, and the circumstances which determine their composition.

MEDICINE.

1.—Describe the symptoms accompanying Aneurism at the base of the brain, Aneurism of the Ascending Aorta and Aneurism of the Abdominal Aorta; and the plan of treatment to be adopted in each case.

2.—Give the various causes of Hæmoptysis, including the pathology, and sequelæ, of the morbid conditions giving rise to it; and then state the indications for treatment, with the usual remedial agents.

3.—Write a prescription in full for a child of seven years at the outset of scarlet fever; and then for an adult in the first step of acute Pneumonia; and give the uses, compositions, and doses of the following preparations:—Feris Carb Saccharata, Unguentum Gallæ with Opio, Pilula Hydrargn Subchloridi Composita, Linimentum Iodi, Infusum Gentianæ Compositum, Mistura Guaiaci.

TIZZONI ON THE LOCAL ACTION OF CHLORAL HYDRATE.—In an article in *L'Indipendente*, No. 6, 1876, Dr. Guido Tizzoni, of Pisa, observes that the first effect of the application of solution of Chloral hydrate to parts deprived of epidermis and epithelium is a transient irritation, varying in degree with the strength of the solution. This is followed by an anæsthetic action, in regard to which the observations of Drs. Coignard, Horand, and Puech, have been confirmed by the author.

The irritant action favours the development of cellulo-vascular granulations, and accelerates the cicatrisation of solutions of continuity. The chloral acts also as an astringent, and as an antiphlogistic. The irritant action, which is generally of brief duration, having ceased, there is in a few hours an arrest of the inflammatory processes, including suppuration: this appears due to the retardation of the circulation and the constriction of the capillaries, as well as to minute coagula and embola, which are found in the vessels and cut off or diminish the local supply of blood—a fact which has been established by the experiments of the author and of Dr. Fogliata.

The most important properties of chloral in surgery are those which it possesses as a disinfectant, antiseptic, antiputrescent, and antifermentative remedy. The author has used it for the preservation of flesh, milk, urine, etc.; no change being perceived at the end of two months. He recommends chloral in ordinary surgical practice, as a preservative against local and general infection, and as a restrainer of suppuration.

He describes the experiments and clinical observations which he has made with regard to the action of chloral, especially as an antiputrescent. The ultimate results were always the same, differences depending only on the amount of chloral used. The solution which he employs is one of ten parts of chloral in fifteen of water.

He has treated, both in hospital and in private practice, many cases of acute and chronic urethritis with injection of chloral hydrate, in the manner recommended by Parona, and has found the result to be rapid cessation of the discharge, and cure of the disease without complications.

GASTROSTOMY.—A correspondent in Paris of one of our daily contemporaries gave recently an interesting case of this rarely successfully performed operation. The patient, a lad of seventeen, had inadvertently swallowed a quantity of the solution of caustic potass. This occurred in February, and in spite of the most skilful treatment, the constriction at the upper orifice of the œsophagus became so complete, that death from iranition must inevitably have ensued without an operation, which was accordingly performed on the 26th July, by Dr. Vernouil, in the Hôspital de la Pitié, Paris. On the 10th September the patient was in good health, remaining up all day, and even helping the hospital assistants in their work; he had almost as much strength and energy as he had before the accident. His diet, composed of soups, fine-chopped meat, mashed vegetables, and drink, was injected through a large elastic tube inserted in the incision made in the stomach. Under this treatment he gained upwards of 10lbs. in weight between the 18th of August and the 14th September. At the moment of the injection of food a flow of saliva in the mouth is produced, in the injection of which a motion curiously resembling the action of chewing is remarked; he can distinguish between warm and cold substances, but otherwise all are indifferent to him. It is stated this is the first time the operation has been successfully performed; the last time it was attempted, but unsuccessfully, was in 1849, by M. Senillot, Professor of the Faculty of Medicine of Strasburg.

GUY'S HOSPITAL GAZETTE, *FEBRUARY*, 1877.

ON referring to the statistical account of patients treated in this Hospital during the year 1875, as given in the last number of the Guy's Reports, we find some interesting details respecting the out-patient department. Taking all the sections together there were 61,438 cases prescribed for in this department, without counting minor accidents and dental cases, which would increase the total by some 12,000. At the surgical out-patients the grand total amounted to 44,676, divided in the following way:—3,313 received letters entitling them to eight weeks attendance, and who were prescribed for by the Assistant-Surgeons themselves; while 41,363 were seen and prescribed for by the dressers. This vast number supplies food for reflection. In the first place it is evident that such a department meets a felt want, for although a certain proportion is always made up of maligners, yet experience shows that the very great majority consists of cases really requiring and receiving benefit from the treatment, and a further proof is that the numbers fluctuate but slightly from year to year. Whether the *morale* of the out-patient world suffers from this wholesale charity we do not mean to discuss now, but experience here again shows that the vast majority are really poor people in need of advice and treatment, and one thing at any rate is certain, namely, that thousands of half-starved and neglected children derive immense benefit from the cod liver oil and steel wine alone, to say nothing of the advice so freely given to the parents concerning diet and general hygiene. The out-patient system then, if properly managed, and if superintended by suitable persons, is the means by which much relief may be given, and much useful knowledge disseminated among the masses.

Let us now look at this branch of hospital practice as a means whereby the student of medicine may gain experience and a store of knowledge for his future public life. Here again the vastness of the field is to a certain extent a guarantee, not only are many and varied forms of disease to be seen, but many examples of the same disease also in its different stages and under different conditions of life of the patient. The latter fact is especially valuable for it is thus possible to gain a thorough knowledge of a few of the most general affections; this is notably the case with syphilis which is *facile princeps* among the causes of the morbid conditions of such a large percentage of the patients.

Some months ago we made an analysis of 400 cases taken immediately from the surgical out-patients; in every case the diagnosis was certain. The result showed that syphilis in its primary, secondary, and tertiary manifestations was the cause in 14·75 per cent. of the cases, while gonorrhœa (acute and chronic) gave 11·25 per cent.; the next highest was ulcers, which gave 11·2 per cent., with the exclusion of ulcerations due to breaking down of syphilitic deposits, and including all ulcers of the legs, whether specific (where the diagnosis is so often uncertain) or not. We learn then that syphilis and gonorrhœa, according to this analysis, form rather more than a quarter of the whole number of cases. Going more into detail it was proved that secondary manifestations were the most numerous, while but few true Hunterian chancres were seen in men, and in only one case in a woman, who had a very well marked one in the lower lip. Hereditary infantile syphilis can be also well studied, several good cases occurring among the above; we maintain then that a thorough good knowledge can be obtained of the large and important subject of syphilis, in all its manifestations at our out-patients department. Another important class of cases, namely, affections of the joints are also plentiful: they form 3·5 per cent. of the cases, and include chiefly two varieties, hip and knee. Sigovitis gives 2 per cent.; the early stages of morbus coxæ are often well seen, and good cases of pulpy disease of the knee-joint are not uncommon. Nævi give a percentage of 3·5, and the various methods of treatment, which is usually prompt, can be seen. Affections of the breast, including chiefly abscess and tumours, occurred to the extent of 2 per cent., but the numbers fluctuate very much, sometimes two or three cases may be seen in a single afternoon. Herniæ are not so frequent as might be supposed, but enough occur to obtain practice in diagnosis; cases of hydrocele are plentiful; rickets is but too common in many of

the half starved children. Besides these diseases, which give the highest percentage in the analysis, there occur less frequently, but still often enough for learning diagnosis, the following:—nasal polypus, fistula in ano, sebaceous cysts, bronchocele, tonsilitis, stricture of urethra, ozæna, epithelioma, hæmorrhoids, &c., &c. Enough has been detailed to show that on account of the number and variety of the cases, the out-patient room is perhaps the most valuable place wherein to learn the diagnosis of disease, and also that a few very important and widespread affections may be also thoroughly studied in their history, course and treatment. Note books are not as common as they might be in the out-patient room; much practice in briefly and accurately describing diseased parts may be obtained by making a few notes on each case as it comes in; to give a good description of a diseased knee-joint for instance is by no means easy, and can only be acquired after considerable practice. If a little more system were introduced, and rather less crowding allowed, time would be saved and more work done, but even as it now stands we cannot overrate the value of our out-patient practice to the student as a means of gaining practical acquaintance with disease.

Mental Diseases.

By Dr. G. H. SAVAGE, OF BETHLEM HOSPITAL.

NOTES ON LECTURE VII.

DEMENTIA.

This is the state of weak mindedness that in the end resembles idiocy, only in this the mindless condition is the result of mental ruin and not mental want from the first.

The result of acute mental disease may be chronic mania, chronic melancholia, or dementia; in the former a patient establishes a mental balance that differs from the normal but is consistent with itself, and one can conceive of a set of beings differing from ourselves having such an altered balance. One chronic maniac we had recently in Bethlem had all her ideas of good and bad changed into ideas of color, and thus would speak of "a white upright" as absolute good, and "a black round" as absolute badness, and she considered a square red as bad, but not so very bad. Under this idea she threw a white handkerchief—a white square—into the carriage of a distinguished visitor as a mark of approval, but was misunderstood as might be expected. Dementia may be complete or partial; it may be also acute or gradual. As the result of acute mania or melancholia it is usually slow and progressive.

A patient has one or more attacks of insanity, and instead of recovering, gradually loses will, affection, memory, and finally all but automatic power. It is quite an accident, or I might say it is quite indifferent whether a patient has mania or melancholia, either may end in mindlessness. The acute stage of excitement or of misery passes off and leaves the patient dull and unfit for work or pleasure.

It is of great importance to detect whether this is a stage of recovery or one of degeneration. Many acute cases for a time are dull after the excitement, especially many cases following acute general disease or puerperal conditions.

In nearly all cases following fevers or inflammations of the lungs I have noticed this dull, partially demented stage, but in such cases the prognosis is favorable. I look for it in these cases and expect it to last till the general health is re-established. If after an acute attack of insanity this stage of dulness is prolonged and does not change, the prognosis is bad; and this is worse if progressively the mind becomes weaker, as shown by loss of power, of will, and especially of memory of recent events.

Acute primary dementia may occur under general very distinct conditions. It may result from sudden shock or fright, and in these cases may be curable. It may follow local injuries to the head, as from blows or sunstroke, and be less curable. It may follow acute disease and be fairly curable. It may be part of general paralysis and be quite incurable.

In all, the symptoms are similar. The patient suddenly or gradually seems altered, he no longer takes an interest in his occupation, gives up his situation and mopes; he does not seek change of scene, as in many cases of melancholia, but often keeps his bed; he exhibits no affection or interest in his surroundings. He slowly becomes more and more dull, is not actively troublesome but likes to be clothed and fed.

The one characteristic is passiveness. In many cases of melancholia we get a similar appearance, but in these we see the patient resist any interference; in dementia we see him submit without any resistance. Melancholy with stupor is most like this, and in some cases the diagnosis is difficult; but, if the patient recover, we find the latter have had some fixed delusion of a painful nature and have a memory of it after recovery, whereas in the former no memory remains. It is not necessary to go into particulars as to the mental functions, it suffices to say, that, in melancholy, a cloud obscures but does not obliterate, but in dementia all functions are in abeyance, and if the patient recover simply a blank remains.

As might be supposed in acute dementia the patients have to be fed and tended as children; they neglect themselves, and are dirty in habits; they often sleep well, and eat if fed. The circulation is feeble, and I obtain the weakest pulse tracings in these cases of any I take.

The state depends in many cases on great physical weakness, or at least occurs with it, and in treating such cases I always give tonics and stimulants. The continuous current and galvanism have often produced good results.

Some writers look upon acute primary dementia as rarely curable, I have, however, seen a fair number get well.

Sudden acute primary dementia.

William P., aged 22, three sisters insane. Returning home one night he was suddenly frightened by an explosion. He went to bed, on the next morning he was found in bed silly and helpless; he could not be roused to do anything.

On admission he was weak and flabby, nothing seemed to affect him.

After trying general measures to improve his health, the continuous current through the head was tried, and this was continued for some months—daily. He slowly recovered and was astonished to find himself in the summer when his last memory was of the winter. The great interest of this case was that his first memory was of the continuous current, making one believe this really helped his cure.

The case was also noteworthy from the strong inherited tendency. Shocks of this sudden kind yearly send us cases of dementia. In one, a house on fire; in another, a cyclone in a midshipman's first voyage.

Acute shocks are not, however, necessary. We see cases in which early masturbation steadily leads to dementia, and in these cases the progress is slow. A lad gradually becomes anœmic and irritable, unfit for his calling, and we find in his history that he has had several situations which he has held for short periods. He is admitted into an asylum because of his unfitness for his sorrows and any outside, and slowly loses what power he has.

I think I have seen a few cases that owed their weak mindedness to over application to one occupation or constant worry.

The cases associated with masturbation are very unfavorable, but those due to exhaustion and long continued worry in persons of middle age are worse. As we said, the dementia may be partial, as seen in this case.

Florence D., single, 19. Cousin insane. Supposed cause, over study. Always distant and proud; gradually six months ago became more reserved and distant. Would not do her work as shop-woman and became more and more unoccupied and untidy.

On admission.—She was a dull, stout, heavy-looking girl. She would do nothing but stand alone. Nothing seemed to affect or interest her, yet she could be roused to speak, and if teazed would be violent. For months nothing did her good. She had shower baths, galvanism, and constant teazing. We then tried cutting off her hair and blistering her nape. After this she improved somewhat, and I think may slowly recover. She was never dirty, and never actively troublesome, and never melancholy.

Cases following the puerperal condition are very common, and we have cases that time after time have similar attacks. We shall notice these if we have occasion to speak of puerperal mania.

After pneumonia we recently had one case, in which the woman would lie about the gallery regardless of decency, of heat or cold, careless of all surroundings; but as health improved, she improved and was discharged well.

I must defer to my next my notice of other cases of weak mindedness as seen in general paralysis, and as a result of acute mental disease.

Physical Society.

Meeting December 16th, 1876.

Mr. C. G. LOWDELL read a paper on "Congenital Malformations," showing how malformations might be produced artificially, both in animals and plants, by imperfect nutrition. He discussed the various ways by which the supply of food to the human fœtus in particular might be interfered with, and other means by which its growth might be hindered, and after the question of amputation by the cord in utero was gone into, he concluded that such was never the case.

Confining himself to the more practical points, he then mentioned some of the more common malformations that were met with of the limbs, different apertures of the body, genital organs, and heart.

Mr. SHAW expressed an interest only in those cases of Congenital malformations which were amenable to treatment, either medically or surgically. He would call attention to Syphilis as a frequent cause of malformation, especially congenital fracture of which he had lately seen two cases affecting the clavicle, as well as two cases of congenital dislocation, one of both hips. With regard to imperforate anus, he called attention to a case now in Lydia ward—on which Mr. BRYANT had performed Littre's operation, professing to open the abdomen on the right side with the certainty of finding the colon—to the probability of missing the decending portion on the left. He suggested that some forms of stricture of the rectum in elderly people might be due to fœtal disease at the junction of the intestine with the rectal pouch; and in speaking of congenital harelip mentioned a case of deficiency of the left eyeball—left ala noæ and fissured palate. He created some amusement by relating a case of congenital malformation in the progeny of an illtreated cat, whose tail after fracture had united at right angles, the kittens of which were all born with tails in the same erect position.

Mr. UHTHOFF said that he had seen one of the cases related by Mr. LOWDELL; the man, notwithstanding his deformity, wrote well, the pen being held in the cleft between the metacarpal bones. He referred to the views of Drs. WILKS & MOXON that malformations of the heart are the result of Endocarditis in utero, and not of a want of development, as generally presumed. He did not believe that fright or any change of mental condition of the mother during pregnancy could cause malformations in the fœtus, any more than of part of her own body.

Mr. L. W. REYNOLDS in speaking of congenital harelip and the time most appropriate for operation, fixed it at three weeks after birth; though perhaps earlier if there be much difficulty in suckling. He quite agreed with Mr. LOWDELL to amputation of limbs in utero, by the umbilical cord being a physical impossibility, as the necessary pressure on the umbilical vessels would cause the death of the fœtus.

Mr. LANE could not agree with Mr. UHTHOFF with respect to the absence of connection between the fœtus and the mother. He had known one case in which the children had all six fingers and toes like the mother, whilst again the frequent resemblance of a child to its mother shows that some connection between them must exist. He then mentioned the case in which a woman with a cicatrix on the lip gave birth to a child with harelip; a harelip being often succeeded by a cleft palate in the same way.

Mr. WAINEWRIGHT differed from Mr. LANE in considering Rickets a congenital malformation; thinking it rather due to malformation. He referred to a couple of cases of congenital malformation mentioned by Mr. HILTON in his work on "Rest and Pain," one of congenital occlusion of the foramen allowing of interchange of fluid between the fourth ventricle and the subarachnoid space of the spinal cord from which bad effects resulted; the other of double dislocation of the hips with lordosis simulating hip-joint disease. Cases of six toes on each foot had been mentioned during the discussion; he had seen lately seven toes on each foot.

Mr. MEEK observed that one part of the Therapeutics of congenital deformities had been omitted, viz., the mother not having been sufficiently supplied with nutriment whilst bearing the child. He reminded the audience that Mr. BRYANT mentions a case in which the children were all congenitally diseased, owing to the badly nourished state of the mother, and that upon this being improved she gave birth to healthy children.

Mr. ELCUM said there was a tendency amongst the speakers to show that malnutritions had more to do with congenital malformations than any other thing, but he would like to know how it was that most of the cases in which congenital malformations occurred were the offspring of well formed and nourished parents—and not only this, but were often themselves parents of well developed children—and instanced the example of the late Mr. Kavanagh, M.P., who without arms or legs was born of healthy parents and grandparents, and was the father of a fine family. He thought they were dependant upon some constant though unknown law rather than upon malnutrition.

Mr. DOWNS could not believe that congenital malformations were due to any influence on the nervous system of the mother, alluding to Talipes in support of this assertion.

Meeting January 19th, 1877.

Mr. G. A. WRIGHT read a paper on "Some Methods of Dressing Wounds;" the following is an abstract:—

The object of all dressings is either alone or in conjunction with other means to obtain the most perfect possible restoration of wounded parts to their previous normal condition. This object is most likely to be obtained when primary union is possible, when this mode of healing fails one of the less perfect methods of repair must be encouraged. Hence dressings may be divided into Natural and Artificial dressings, the former include the method of healing wounds by blood, Tr. Benzoin Co., &c., in imitation of the mode of healing occurring in wounds in the case of animals with hairy coats, *i.e.*, a dressing is formed of matted blood and hair. The Artificial method includes antiseptic and various other dressings.

In the use of antiseptics great care is neccessary that all instruments, &c., should be thoroughly soaked in the antiseptic, that generally used being carbolic acid, also that the dressing should extend well beyond the wound to prevent decomposition extending from without inwards also, as Professor LISTER insists, that the antiseptic should as little as possible come into actual contact with the wound in order to avoid the effects of its irritant properties. Another important point in this mode of dressing is the use of the drainage tube, which is especially necessary in consequence of the irritation set up by the carbolic acid or other application.

The advantages claimed for LISTER'S method are its power of checking Hospital Gangrene, Pyæmia and Erysipelas, its power of rendering detached bone, in the case of compound fractures, &c., capable of being absorbed. It is also said to increase the proportion of wounds healing by primary union, and to diminish suppuration and tend to preserve patients from surgical fever, as well as to shorten the duration of treatment. Also this mode of dressing is less painful than other modes.

The alleged disadvantages are delay in healing, possibility of carbolic acid poisoning, and the trouble incurred in the use of this method; the two former drawbacks are generally due to mismanagement, the latter is mentioned by the time during which dressings may be left on.

Besides carbolic acid, bromine, iodine, turpentine, chloral, salicylic, and boracic acids, as well as many other application have been recommended as more or less complete antiseptics; of these salicylic and boracic acids are the most important, and the latter probably the most effectual.

Satisfactory statistics as to the merits of antiseptics and other dressings are not yet attainable, as far as they go at any rate at Guy's antiseptics when properly carried out appear to be the most successful. It is not however nearly universally adopted in the London Hospitals.

Other forms of dressing are numerous and comparatively unimportant in so far as the special merits of any one form are not prominent, they are used either as universal dressings for all wounds, *e.g.*, oiled lint, and wet and dry lint, or are directed to some special fracture of a wound, *e,g.*, deodorant, anodyne, greasy, &c., dressings.

The "Open Method" appears at first sight dangerous, but good results have been obtained with it at the Westminster Hospital, and in America, &c., as well as at Cambridge.

If the Natural method and antiseptics are both excluded, dressings must be applied in accordance with the general rule laid down by Sir J. PAGET as regards frequency of dressing, lightness, warmth or cold, and exclusion of foreign matter.

Mr. WAINEWRIGHT, in opening the discussion, said that the subject of the evening was one for practical men to discuss, and that it was one of the first importance. If pyæmia and erysipelas be really absent when LISTER'S method is in use, then the antiseptic method of treating wounds must be regarded as one of the most wonderful advances of modern surgery; this method also includes the use of boracic lint and chloride of zinc.

Mr. SHAW said that the inconveniences of the antiseptic method is a matter of consideration in private practice; he inclined to the natural method, as described by Mr. WRIGHT, especially in cases of incised wounds, cleanliness and prevention of decomposition of pus were the great desiderata and both were securable by the scabbing process without the use of carbolic acid. He further said that of fifteen cases sent up by two surgeons into erysipelas ward last year, eight were sent up by an antiseptic surgeon, and seven by non-antiseptic; Mr. BRYANT, he added, used terebene and iodine chiefly as deodorizers.

Mr. MAYLARD thought that variations of temperature was an important point, because all the natural processes in the body take place at a certain temperature. In healing of wounds, two things happened, a formation of new tissues, and disintegration of tissue; the latter process gives rise to chemical action, with formation of oxygen and consequent rise of temperature, we should endeavour then to favour this rise of temperature.

Mr. COLEY thought that the theoretical side of the question might be interesting. LISTER based his system on the germ theory. Mr. HOWSE holds that decomposition is the special danger, and that decomposition is due to the entrance of germs; the speaker's own experiments showed that no decomposition took place in organic infusions when in sealed tubes. Prevention of decomposition he thought was the great desideratum, and next to that to guard against the entrance of germs.

Mr. HORROCKS thought the subject both interesting and important, every surgeon appeared to him to have a different method for dressing wounds, and all, in the majority of cases, got about equally good results. Antiseptic dressing had been tried at St. Thomas's Hospital and given up, the results not repaying the extra trouble and expense of the method.

Mr. UHTHOFF thought the variety of the methods named showed how far we were from a perfect manner of dressing wounds. Two particulars ought to be aimed at: (1) to get healing of the wound as rapidly as possible; (2) to reduce the risks of the patient to a minimum. He thought antiseptic dressing retarded the healing process, and that other methods entailing much less trouble were followed by as good results. He spoke of Dr. GANGER'S notion that dressing ought to be changed as little as possible. He thought germs could have but little to do with putrefactive changes in wounds, or the

results of the various dressings would show more marked difference.

Mr. A. K. MORGAN spoke of the disintegration of the nitrogenous tissues in reference to the increased heat in wounds.

Mr. DUKE questioned Mr. SHAW'S statement as to the prevalence of erysipelas after antiseptic surgery, believing that when this followed it was due to imperfectly attending to the details of the method.

Mr. LEE thought the prevalence of pyæmia in many hospitals proved that crowding and unhygienic conditions set up a constitutional state unfavourable to the healing process, which must be altered by putting patients under the best hygienic conditions.

Meeting January 6th, 1877.

Mr. WAINEWRIGHT began his paper by referring to the various names which have been given to the sympathetic nervous system. The paper referred to the development, minute and comparative anatomy, the physiology, and the pathology of the sympathetic, special attention being given to the last two.

The account of the development of the sympathetic was based on the investigations of Remak and Kölliker. Attention was drawn to the fact that the suprarenal bodies are connected with the sympathetic, both in development, anatomical characters, and pathology. A concise description of the minute anatomy of the sympathetic was given, based on the views of Stricker, Quain, and Grey. In a short reference made to the comparative anatomy of the sympathetic, Mr. WAINEWRIGHT stated his opinion that, in the invertebrata, the sympathetic and cerebro-spinal systems were undifferentiated.

In speaking of the physiology of the sympathetic, a full account of the nervous mechanism of the heart was given, illustrated by a diagram kindly drawn by Mr. G. MACKERN.

The functions of the vasomotor nerves were very fully entered into, and many experiments were quoted proving that vaso-dilator or vaso-inhibitory fibres existed as well as vaso-constrictor. It was also shown that, in addition to the vasomotor centre in the medulla oblongata, there are also local perivascular centres, and also secondary vasomotor centres all along the cord, and probably in the cerebral cortex.

Reference was made to the theory that there is a constant peristaltic action in the arteries during life.

The action of the sympathetic on the iris and the muscular fibres of the stomach and intestine were then noticed, and afterwards the influence of the sympathetic on secretion, especially of saliva and gastric juice.

The diseases spoken of, in which the sympathetic is implicated, were diabetes, epilepsy, Grave's disease, tumours pressing on the sympathetic, paralytic dementia, fevers, and hysteria.

Mr. WRIGHT suggested that the view by which the abdominal sympathetic ganglia were looked upon as "dampers" of unnecessary sensation, might be developed by considering the structure and arrangement of the nerve cells, viz., that stimuli passing to one pole of a multi or bi-polar cell through a nerve might be conveyed by another process to the fine network existing between the processes of the larger cells and the small less specialised cells also found in ganglia, and so, by diffusion of the stimulus in many directions, its power might be lost. As regards the comparative anatomy of the sympathetic, the relation between the rod of condensed tissue (the notochord), found in the ventral portion of the abdominal walls of many invertebrata, *e.g.*, some vermes and some of the lepidoptera, and their nerve chain possibly indicates the homology of that system with the sympathetic of vertebrates generally, especially as there is reason to believe that the present dorsal and ventral aspects of those animals are the reverse of the original ones, and that the fourth ventricle of vertebrates is the site of the primordial mouth. The speaker asked for information on the question of the influence of increased pressure in the vessels upon the heart's action, and on the way in which conflicting statements in text-books upon that subject could be reconciled.

Mr. UHTHOFF, in reply to Mr. WRIGHT'S question, remarked that there were two forces to be considered: first, the action of the blood pressure on the centres in the medulla; second, its action on the lining membrane of the heart, and so on the intra-cardiac ganglia. Now, increased blood pressure by stimulating the vagus centres, tends to cause a slowing of the heart's action, and at the same time, by its action on the intra-cardiac ganglia, has an almost exactly opposite effect. Whichever of these actions predominate, so there will be increased or diminished action of the heart. He also observed that in most cases the dilatation of arteries, produced by stimulating a sensory nerve, was due to the inhibition of the vasomotor centre in the medulla; but that stimulation of the chorda tympani and of the nervi rigentes of the penis produced the effect when the peripheral ends of the cut nerves were stimulated, so that we must conclude that there are secondary vaso-inhibitory centres.

Mr. HORROCKS was prepared to find the paper rather dry, but he thought it was a most valuable one, not so much perhaps to first and second year's men as to the more senior men. The action of the pneumogastric on the heart was most important to know in cases of disease. Knowing its inhibitory action, the battery should never be applied to both pneumogastrics at once, as fatal results have been known to take place. Blushing was explainable by action of sympathetic, and much light also was thrown on the processes of inflammation by a knowledge of the existence of vaso-dilator and vaso-constrictor nerves. He contended that the sympathetic has as much influence on digestion as it has on the heart.

Here Mr. MAYLARD suggested that Mr. WAINEWRIGHT read the remainder of his paper, namely, that concerning the pathology of the sympathetic. After this had been done—

Mr. G. MACKERN thought that more light would be thrown on the functions of the sympathetic according as our knowledge of comparative anatomy increased. He thought it was a significant fact that all the processes of nutrition and reproduction were ruled over by a ganglionic system of nerves in the invertebrata generally. He then alluded to the nervous organisation of the *Petromizon*, but explained it by the fact that it was one of the lower *Pisces*. Reason and instinct also apparently were not absent in the invertebrata, and quoted the habits of ants in support of his statement; he also drew attention to the grouping of the ganglia in the cephalic region in the molluscs, and the near approach to the brain cavity in some of the cephalopoda. He inclined to the belief that the nervous system of the invertebrata was the malogue of the cerebro-spinal system of the vertebrate.

Mr. DOWNES thought that Mr. WAINEWRIGHT had given a sufficient explanation as to why the sympathetic system should be regarded merely as an effect of the cerebro-spinal. He thought that the habits of ants, as instanced by Mr. MACKERN, were due to reflex stimulation occurring at the appropriate seasons. He then made some references to the researches of Dr. Beale and Aruold on structure of ganglion cells.

Mr. ELCUM said that the idea of the sympathetic being an effect of the cerebro-spinal system was compatible with the physiological law of Van Baer, that development is from the general to the special.

On Personal Investigation into the Actions and Uses of Medicines.

W. A. KIDD, M.B., LOND.

It is of extreme importance that when we administer remedies to patients, we should do so with confidence. This, of course, all must allow; but do we all enjoy this confidence? Many, indeed, are the cases in which we give a certain medicine for a certain condition, ignorant of the manner in which it will act, giving it because so-and-so has found it efficacious in the above condition. In such cases we have not a profound confidence in its value, and generally manifest this by giving with the remedy others which we *know* will be beneficial to some extent. Then comes to us the rather pressing question (for I presume we should all ask ourselves such questions) has this remedy produced the improvement or cure which I see has taken place, or is it to be attributed to the other remedies which I have combined with it, or even to nature alone? The latter part of this threefold question will be decided to a great extent by our knowledge of the usual course of the disease we are considering; the second part is often forgotten altogether, though with great care this fallacy may be eliminated; the first part is too often, I fear, answered according to the prejudice existing in the mind of the practitioner, and some important consideration is left out of the investigation. The remedy is then lauded or condemned on insufficient grounds.

This is written from the stand-point of a student in the real sense of the word, and in these remarks it is assumed that all other students, when they have read and digested the information which books on therapeutics have to give, are desirous, some more, some less, to learn for themselves, and are occupied in learning what they are to depend on in the future, when sick persons shall entrust themselves to their care, they will then long for something more than elegant prescriptions and purely theoretical remedies. It must not be understood that I think that we must all set ourselves to verify or disprove the opinions that mercury and iodide of potassium have a curative and palliative effect upon syphilis, that quinine will cure ague, and digitalis relieve some diseases of the heart. These, indeed, can hardly be called opinions; they, and many of their kind, are facts; facts wrought out for us by our predecessors and teachers at the expense of much toil. We need only to know more fully how such trusted remedies act, and to discriminate more precisely when and how we shall use them. But unfortunately mercury, iodide of potassium, digitalis, even with the addition of opium, will not cure or relieve all diseases. It is the investigation of the less trusted and certain remedies of which I wish to speak. The small credit of these among the profession depends on at least two causes:— First, some of them have been put forward on theoretical grounds, have been tried in a languid manner for many years, have occupied all the time a respectable position in the British Pharmacopœia, and have never decidedly, in practice, justified their position in their assigned provinces; Secondly, the physiological action of others is little known, and their reputation depends solely upon the experience of men liable, as all are, to errors of observation and consequent erroneous conclusions. The first class will find their level in due time, and all we need do for the time is to ignore such of them as we have good reason for doubting. But the second class are those on which the hope of scientific therapeutics must depend for their increase and extension. If their careful and honest investigation is neglected, medicine, in this respect, will remain at a stand-still and then, perhaps, go back instead of advancing; and men will become either sceptical of all beyond a small trusted circle of remedies, or trust to their own individual experience of other remedies, which experience will be of an untrustworthy kind. The knowledge of many will remain where it was when they learnt their therapeutics out of a small text-book on medicine or a pocket remembrancer of materia medica and therapeutics, and were able to pass an examination in medicine, and then entered upon practice with a definite stock of knowledge on this subject, good as far as it went, but not to be added to. But we are persuaded better of this generation; we ought to be most thankful for the numerous investigators busy with the laborious work of experimenting, and not to neglect our own part in this matter. We may not all have the capacity, and certainly most of us have not the time, for the pursuit of scientific experiments into the action of medicines, taking the word "experiment" in the sense which it so generally receives now, viz., of experiments on animals; but we can and we ought to make experiments on patients. This idea will horrify some people, but, perhaps, such forget what an experiment is. If we desire to try some remedy recommended in a certain disease, and besides this we know of some other remedy which will relieve, to some extent, the disease in question, we shall hardly be justified in with-holding the latter; no, we must do the patient what good we can, and, in spite of the difficulties, apply the usual treatment at the same time, with due regard to all fallacies, administer and watch the effect of our remedy. If this is done more or less by all practitioners, they will all be helping forward the science of therapeutics in a manner slow, doubtless, but certain of true results in the end; they will all, indeed, be performing experiments, and the conclusions of the numerous strictly scientific observers now at work, who have less opportunity for appeals to clinical investigation, will be verified on the one hand and

checked on the other. Thus will much of the unfounded reputation attaching to some remedies be taken away, and the reputation of the rest be established on a firmer basis; and, to return to our former point, we shall all have more confidence in treatment, for much of the baseless theory and crude experience which is mixed with therapeutics will have been cleared away by means of the two great enemies of false opinions in these matters, viz.:—

(1) The investigation into physiological action of remedies in man and the lower animals.

(2) The verification of the laws deduced from these experiments by appeal to clinical experiments of the kind advocated above.

Football.

GUY'S *v.* OAKFIELD.

Played on our ground, and after a rough and hardly fought game resulted in our favour by 3 touch-downs to nothing. The crowd simply penned in the players, and so prevented, to a great extent, running, &c.

GUY'S *v.* CLEVEDON.

A very weak team and two short arrived to play this match, and so it resulted, as might be expected, in a defeat by 2 goals to nothing. Howell, unfortunately, hurt his knee soo after the game had begun and had to retire, and so we were playing three short for the greater part of the time. Jackson's play in this match deserves especial mention.

GUY'S *v.* BART'S.

Played on their ground at Battersea Park, and resulted in a win for Guy's by a goal to a try and 4 touch-downs. Our team was very weak and two short. Gray kicked the goal from a very difficult place.

GUY'S *v.* A SCRATCH TEAM.

A "training" match was played on February 3rd, consisting of the team that will probably represent us for the Cup, and a team consisting of 24 got up by Mr. Hill. The fifteen played exceedingly well, and after 1½ hour's play had won by 2 goals, a try and 2 or 3 touches to nothing. The fifteen were—

W. G. Gray (capt.) and A. H. Jackson (half-backs), L. Stokes (three-quarter-back), A. W. Pearson, E. Penny (backs), J. C. Keer, F. J. Wilkinson, J. Fraser, D. D. Roberts, R. Stanley-Taylor, H. Liddell, J. Boswell, J. Rees, Q. Veitch, J. Lister, but the committee, if they think fit, may make any alterations.

There is a rule in the G. H. F. C. that any gentlemen over their fourth year may not play for the challenge cup, so this year we lose the services of Gilbert, Maclean, and Welchman, also Howell on account of his accident.

Two more scratch matches will be played before the ties come off, so our team ought to be in good form and training; last year, undoubtedly, this had everything to do with our losing the cup.

The ties were drawn as follows, and will be played on these dates:—

Monday, February 12th, Kings' v. St. Thomas's.
Tuesday „ 13th, University v. London.
Wednesday „ 14th, Bart.'s v. St. Mary.
Thursday „ 15th, Guy's v. St. George's.

The date of the final match is March 6th, but this may be altered.

The matches will be played at the Oval, and will commence at 2·30 punctually, and play will be for an hour and a half.

The following mode of scoring will be adopted, as at previous cup matches:—

3 touch-downs will equal 1 try.
3 tries „ 1 goal.

GUY'S *v.* BECKENHAM.

Played at Beckenham, on Saturday, February 3rd, and was won very easily by Guy's by 6 goals, 2 tries, and several touch-downs to nothing. The tries were obtained by Liddell, 3; Keer, 2; Jackson, 2; Taylor, 1. Jackson placed the goals. Guy's played 1 less than their opponents. J. C. Keer (capt.), A. H. Jackson (half-back), T. Shepherd (three-quarter-back), E, Penny, Q. Veitch (backs), H. Liddell, F. J. Wilkinson, R. Stanley-Taylor, D. D. Roberts, J. Boswell, J. Rees, J. Lister, — Trott.

DOUBLE ACROSTIC.

We are not quite the same, and each one knows
Us well apart as from a thorn "the rose."
Our dread effects are feared by the physician,
Still more the surgeon, and the obstetrician.
We are blood poisonings, and though some have tried
By "vaporous" means to thrust us both aside,
'Twas but a doubtful victory. Perhaps
To call ourselves about the worst mishaps
That surgeons have to fear would be our right;
While medicine and obstetrics dread our might.

1 I swoon, she cried, and fell upon the ground.
Then salts were brought—she very soon came round.

2 The compound tinctures, essences the same;
The Arabs often called them by this name.

3 In many bad conditions 'tis quite plain
The best course is the opening of a vein.

4 The young all have me, though I cease to grow
After two years; perhaps you better know
Me in the calf, in which I certainly
Can hardly doubt that you have eaten me.

5 The arm seems thin; on looking you can tell
That we are wasted in the hand as well.

6 Poor child! its ringing cough, its breathing too,
Tell but too well with what we have to do.

7 Leslie invented me in demonstration
Of how much all the clouds stop radiation.

8 The præsystolic bruit, the thrill prove how
Some orifice must be constricted now.

9 You cannot sleep; one thing might set you right,
A dose of chloral you must take to-night.

10 A fluctuating swelling, pain; I fear
The knife will be the only treatment here.

M. L.

OMISSION.

Christmas Decorations in the Wards.—We deeply regret that through a clerical error the decorations in Dorcas ward were not alluded to. We may assure our readers that this omission did not occur from any deficiency in the decorations, for the whole ward both back and front had put on a very festive appearance, thanks to the abundance of evergreens and the good use made of them.

VACCINATION AND RE-VACCINATION.—It would not be difficult to make small-pox epidemics impossible in this country, and why should it not be done? The statistical results of the present epidemic are likely to force upon the attention of the public and the legislature, firstly the immense importance of effective primary vaccination, and secondly the advisability of making re-vaccination after puberty also compulsory. Thus the Registrar-General showed recently that up to November 25th, only one child, out of 317 of the vaccinated children, had died of small-pox, and this one had been attacked before the vesible was sufficiently far advanced to be protected, *i.e.* before the twentieth day. On the other hand the statistics of the small-pox hospitals show that re-vaccination after puberty is practically absolutely protective, the exceptions being so excessively rare as to be outside calculation. To ensure against the possibility of any future epedemic, it is in truth only necessary to amend the vaccination law by defining four vesicles as the minimum that any medical man should at all events attempt to produce, and by making re-vaccination compulsory between the age of fifteen and sixteen. such an amendment of the law would save much sickness, death, misery, expenditure and panic, for it would extinguish small-pox.—*Sanitary Record.*

ON DUTY FOR FEBRUARY.

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Junior House-Physician ;—Mr. A. Kidd.
Dressers for the week :—
G. Ma kern (Mr. Bryant).
T. Judson (Mr. Durham).
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G. A. Wright (Mr. Forster).
Senior in the Charity :—W. P. Reynolds.
Junior in the Charity :—J. T. Brett.

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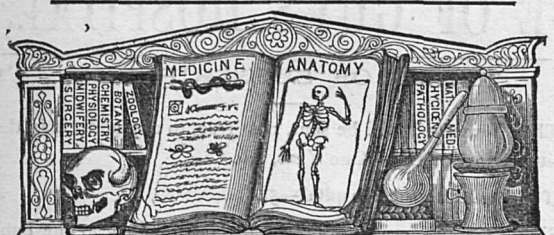

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By MR. BRYANT,

ON CONGENITAL INTESTINAL OBSTRUCTION.

In order to understand the causes leading to this condition we must first go back to the history of the development of the alimentary canal in the embryo. At a very early age the alimentary canal consists essentially of two portions—

1.—Intestinal.

2.—Rectal.

(1.) Travels down in the shape of a tube as far as brim of pelvis, and ends in a *cul de sac.*

(2.) The rectal portion begins as an inflection of the skin in the region of the future anus, the sac so formed gradually enlarges, and finally meets the intestinal portion; the two then join and form a continuous tube.

But this process does not always take place, and the following are the deviations that are liable to happen:—

1.—Sometimes the rectal sac is not developed at all, and the perinæum remains quite smooth, no anus being developed; if there be no anus, then it is also certain that there is no rectum. There is likewise, very probably, a deficiency in the extent to which the intestinal portion has developed, which, more than likely, does not extend beyond the brim of the pelvis. The sex of the individual makes no difference.

2.—Where the intestinal portion opens either into urethra (male) or oviduct (vagina of female), so that a *cloaca* is established; no anus, no rectum. This deviation is more rare than number 1.

3.—Where there is an anus and an anal *cul de sac,* also an intestinal portion. The question then turns on how far the process of development has proceeded. When there is a long anal *cul de sac,* then there is good reason to think that the intestinal portion is equally well developed, and, therefore, that there is only a slight interval between the extremities of the two.

Symptoms,—Are those of intestinal obstruction. Always examine the child yourself, and never trust to the report of the nurse. If no meconium has passed during first two days, then a digital examination is necessary. If there be a well-formed anus, then, in all probability, there will be a well-formed rectum.

Treatment.—In cases showing

First deviation.—It is important to remember that in this case the blind end of the intestinal portion is not constant in left side of pelvis, it is often on the right side, or it may be in the middle line. We ought to try to find end of intestinal *cul de sac,* and, if on pressing with the finger in the anal region a feeling of great tension is experienced, then the surgeon is justified in making an incision through the anus, and, using the finger as a director, cut on gently till the end of the intestine is reached, and then the *cul de sac* may be opened, the finger still guiding the cut; he should proceed in a direction from the anus to the sacrum for about an inch or an inch and a half. Colotomy should never be attempted because of the uncertain position of the intestine. Hugier's operation consists in the establishing of an artificial anus in the right iliac fossa, the end of the gut being more usual in the right side. This operation may be tried when the exploratory incision has failed.

Second deviation.—The cases are rare. The child is not dying from obstruction. If opening into *cloaca* be small it ought to be enlarged. If the gut opens into urethra the case becomes very serious. As the canal always opens into the urethra in front of the prostate, Mr. BRYANT suggested perineal section, using the straight staff, and hitting the urethra in front of the prostate, a fistulous opening into perinæum is thus established. The vaginal opening usually contracts well, though sometimes not for years.

Third deviation.—Cases showing this deviation form the most favourable class for operation. Avoid making a blind plunge with the knife, but pass the finger upwards towards the brim of the pelvis as if aiming at the umbilicus, then the end of the intestinal portion will most probably be at once hit upon.

In all cases were an artificial anus has been made or a *cul de sac* opened, it is an essential element of success that such opening be kept well dilated, and a case was then detailed of a man who was admitted with symptoms of obstruction, and, on digital examination, the finger went into an anal *cul de sac* bounded by a thin membranous partition. This man had been operated on when an infant, and the opening had not been kept properly patent; he had suffered from constipation, the bowels being frequently not moved for a month or six weeks. This case also illustrates the necessity of keeping the bowels active.

ACUTE INTESTINAL OBSTRUCTION.

Mr. BRYANT commenced his lecture by describing an ideal case.—A young adult, usually in good health, is suddenly attacked by severe *abdominal pain* occurring in paroxysms, this is soon succeeded by *vomiting,* and a greater or less degree of *collapse* usually follows. Constipation may or may not have been present, but the mere passage of a motion is not to be much depended on; the beginning of the attack, however, is to be dated from the passage of the last motion.

Symptoms important to remember are

1.—Pain.

2.—Vomiting: first stomach, then duodenal, and finally fæcal from large intestine.

3.—Collapse.

4.—Abdominal distension; almost constant.

5.—Characteristic position of patient.

6.—Pain on pressure in some particular region of abdomen.

The difficulty in these cases is to discover the right

cause, for the following may operate as causes for one or more of the above symptoms:—

(*a*) *Colic.* At first it is impossible to distinguish between this condition.

(*b*) *Perforating ulcer of duodenum.* Is not necessarily fatal; the diagnostic point is sudden pain after a full meal.

(*c*) *Strangulated hernia.* Every foramen in the patient's body through which a hernia may pass should be examined, and then internal strangulation should be thought of.

(*b*) Perforating ulcer of some other part of intestine, especially of *appendix cœci.*

A case was then detailed of a young lady who, on returning from a long drive, went at once to empty her bladder, and immediately after was seized with intense abdominal pain, followed by vomiting and collapse. When seen by Mr. BRYANT, seven hours after, she had paroxysms of pain, iliac vomiting, and a very rapid and feeble pulse; on the right side of abdomen there was tenderness on pressure, and a distended coil of intestine could also be distinguished there. Patient had an intense desire to pass water, but was unable to do so; a catheter was used, but no urine came. A history was given of a "bladder attack" (probably cystitis) when a child. Post-mortem showed a band of fibrous tissue running across from bladder to right side of abdomen, when the bladder was emptied the band must have fallen across the brim of the pelvis and so fastened down a coil of intestine, thus producing the obstruction.

Another case was also given of a man, æt. 18, who was admitted with pain, vomiting, and collapse, and whose bowels had not been opened for seven days. An operation was performed, and, on opening the peritoneum, fæcal pus and fetid pus came up from right side of belly, the cæcum was found gangrenous, and the appendix cœci had sloughed away; there was general suppurative peritonitis.

Clinical Medicine.

CASE OF CEREBELLAR CYST.

Mary M., æt. 21, was admitted into Clinical ward February 14th, complaining of giddiness and sickness.

Family history.—Father died of phthisis; mother is strong woman. Patient is the eldest of 5 children, all with the exception of herself suffer from cough. No hæmoptysis. Patent has always been of a very quiet disposition and mentally backward, not being able to read or write though she has had the opportunity to learn. With the exception of measles when quite a child had not any illness up to the present attack; she has never suffered from ear disease of any sort. Began to menstruate when 14 years of age and has been regular ever since. No history of blow or injury to head.

Four months ago, while at service, patient began to vomit every morning on getting out of bed and also very often after taking food; at the same time she noticed that she was very excitable and had fits like hysterical fits when carrying anything (though she never lost consciousness). The sickness becoming worse she went home, and after six weeks was well enough to return to her situation, but when there grew rapidly worse again and went home again, and remained there up to admission. She came up once or twice to out-patients', but any medicine that she took was immediately vomited.

While at home her mother describes her condition as being very drowsy and listless; always, when out of bed, sitting over the fire and taking no notice of anything going on around her; very irritable if there was any noise. She would take food if it was offered to her, but would never rouse herself to ask for it; was frequently sick, regurgitating the food in a rapid manner soon after swallowing it, and the vomiting was never preceded by nausea.

On admission.—Has a listless and vacant expression, lies on left side with hands often applied to the sides of the head, and not willing to be aroused or make any exertion. Complains of constant headache, which is referred to the left temple, occiput, and back of neck; there is also a "bursting" pain in the left eye, the sight of which is double when object is held inwards or upwards. All these symptoms are much aggravated when the patient makes any movement, but she states that she generally feels better when sitting up than when in bed. She says that she has no energy to do any sort of work, and if she makes the attempt the headache is much increased. She prefers being left quite alone, but answers questions readily and intelligently.

Chest, heart, and abdomen do not present any abnormal physical signs. Tongue, flabby, moist, clean. Bowels not been moved for three days. Urine, sp. gr. 1015; no albumen, cloud of phosphate. Temperature, 98. Pulse, 72; regular, full, not easily compressed.

Ophthalmoscopic examination of left eye showed a slight amount of optic neuritis, the vessels were distinct, margin of disc blurred.

February 15th.—No sleep. Great headache. Vomiting this morning.

February 16th.—Retching again. Headache. Paralysis of external rectus muscle of eye on left side; eye does not move outwards beyond middle line; vision is not double this morning.

February 17th.—Is up and about ward. Headache is not so bad, and is described now as a "numb" pain on moving. On asking patient to walk she rises deliberately from her chair, then seems to wait to steady herself, and, after placing the left hand over the left eye, starts, using the right hand to grasp any object to steady herself; her gait is very shuffling and unsteady, especially with the right leg, and she looks while walking as if she were going to fall at every step, but suddenly regains her balance.

February 18th.—Yesterday while she remained up she was not sick at all, but was very sick again this morning, and the headache is so much worse that she cannot get out of bed.

At times the pain in the head became so bad that the patient called out, applied the hands to the sides and back of the head, and tossed about in bed with the pain. Three of these paroxysms of pain took place during the day, one at 11 a.m., another about 1 p.m., and the third at 3·45 p.m. The last came on with a fit of screaming, due to pain in the head which became very hot; she then remained in an unconscious state for nearly an hour, with her tongue hanging out of her mouth. No paralysis of any part, nor nothing abnormal about the pupils. At 4·40 p.m. she died, the respirations ceasing for fully five minutes before the heart ceased to beat. Some muscular movements but no convulsions preceded death.

Post-mortem, 23 hours after death.

On removing calvariun it was noticed that the cerebral convolutions were much flattened. On looking at the under surface of the brain, all the nerves about the pons and medulla were seen to be flattened and more adherent than natural to the membranes, the sixth nerve of left side being particularly flat and compressed.

The left cerebellar lobe was seen to be larger and more prominent than the right and was softer to touch; a puncture was made into it and about ʒ ij. of an amber coloured fluid escaped, which proved, on testing, to be highly albuminous.

The cyst was laid open and its walls seemed to have quite a simple structure, as if formed of the expansion of the surrounding structures. The cyst was situated outside the corpus dentatum, and nearer the upper than the lower surface of the cerebellum.

The ventricles of the cerebrum were dilated and full of fluid, and the venæ galeni congested.

Lungs, congested at bases.

Heart, 10 ozs.,
Kidneys, 10½ ozs.,
Liver, 64½ ozs.,
Spleen, 5 ozs.,
Brain, 58 ozs. } Healthy.

Cord.—Firm, healthy, central canal not enlarged.

Uterus.—Cavity, large; contains menstrual blood.

Ovaries.—In one ovary a cyst was found about the size of a large orange, containing about ʒ v. of the characteristic brownish fluid. Near the same ovary there existed a small hard lump, which, on being cut into, presented a very regular laminated structure, but was too soft to be due to an old blood clot; the opinion was that it was due to the gradual deposit of fibrinous material.

Physical Society.

Meeting February 3rd.

MR. H. F. LANCASTER IN THE CHAIR.

E. AMPHLETT, M.B., read a paper on "Insular Sclerosis, and its diagnosis from Paralysis, Agitans, and other nervous diseases."

MR. AMPHLETT first touched on the difficulty of distinguishing, by microscopic examination alone, between Insular and other forms of Sclerosis, such as locomotor ataxy—the morbid process in each being nearly identical. In Insular Sclerosis multiple detached greyish patches of disease were scattered through the brain or spinal cord, or both, and having a marked tendency to affect the white matter in preference to the grey.

Morbid histology.—A formation of cellular and fibrous tissue is observed in the neuroglia, which, by pressure, caused absorption of the nervous elements. In the *white matter* the myelin sheath is gradually destroyed; the axis cylinders became at first swollen, but, when entirely deprived of their myelin, they thin down and ultimately disappear; they resist atrophic changes until a late stage in the disease. In the *grey matter* the nerve cells at first swell up, and, losing their prolongations, become spheroidal in shape, they then atrophy and undergo pigmentary degeneration. He thought that a comparison of the early symptoms of Insular Sclerosis with those of locomotor ataxy justified a theory that, in the latter disease, an irritation of the nerve cells was the initial condition, this irritation subsequently spreading to the neuroglia. In the former the neuroglia was *primarily* affected.

Symptoms.—Paræsis, followed by a peculiar tremor excited by muscular effort alone, nystagmus, embarrassment of speech, loss of muscular power, partial mental imbecility, and, at a later stage, peculiar contractions of the limbs, and, not unfrequently, apoplectiform attacks. Up to a late stage the muscles remained plump and retained their electric irritability, and the sensory functions were unimpaired.

In endeavouring to establish a connection between the symptoms and pathological appearances, Mr. AMPHLETT said that the axis cylinders occupied the place of the copper wire in the case of a telegraph cable, the myelin being the insulating guttapercha sheath. The pathology of the disease showed that the copper wire was damaged, and its conducting power consequently impaired, its insulation was also defective; the paralysis was thus easily accounted for. The tremor was a more complex phenomenon: it was, perhaps, partly due to the destruction of the insulation, permitting the current to pass into wires with which, so to speak, it had no business; the deterioration of the conducting power probably had something to do with it, the continuity was impaired, and consequently the current was transmitted by fits and starts. The tremor, being caused by the transmission of impulses along a diseased tract, was only manifested when muscular action was attempted. The partial exemption of grey matter probably accounted for the absence of sensory troubles.

In discussing the diagnosis of Insular Sclerosis from paralysis, agitans, he said that the latter disease ought not to be confused with senile tremor, and showed that it was as sharply defined as Insular Sclerosis itself. Locomotor ataxy, general paralysis, chorea, senile, alcoholic, or mercurial tremors, and hysteria might

have to be distinguished from Insular Sclerosis, but the first two alone present any real difficulty,

Microscopic specimens were shown, some of which were lent by Mr. F. DURHAM, and others cut from specimens furnished by Dr. GOODHART; several colored plates were also exhibited.

Mr. WRIGHT, in opening the discussion, complimented the Society on having had read before them such a complete account of Sclerosis, a disease by no means common. He thought that in the latter stages of this disease there appears sometimes to be developed a strong personal likeness of one patient to another, the girl now in Bright very much resembles in face the case which was there a short time ago, and this is becoming more marked than it was. In the former of the two cases the gait was very peculiar, in addition to the usual tottering movement there was added a peculiar method of balancing, so that the patient balanced herself, with the help of a stick, on one leg before bringing forward the other. As regards the age at which paralysis agitans occurs, it is said to have been seen considerably under 20. A point of difficulty in the pathology and history of Sclerosis is the explanation of the intermissions in the symptoms, for it is scarcely possible to suppose that parts once sclerotic can regain their power.

Mr. DAVY thought that constipation should be added as a pretty constant feature of Sclerosis, showing weakness of the abdominal muscles, which might be beneficially treated with nux vomica. The diagnosis of Sclerosis from other allied nerve disease was, he thought, not difficult; the "peculiar trembling," "affection of speech," and "nystagmus" being apparently pathognomonic and constant in all cases that could be recognised. He thought the danger was that these symptoms might be overlooked, and a diagnosis of hysteria made, and the fact that what appeared pure hysterical symptoms frequently commenced the disease, increased this danger. He believed so called hysteria was usually the precursor of obscure nerve disease, and thought that in all cases a very guarded prognosis should be formed. He then spoke of the constantly varying intensity of the symptoms in the case of Sclerosis in 18 Bright, pointing out that this seemed to contradict the division into stages which Charcot had made of the disease. As regards the pathology, the constant set of symptoms amongst all the variety proved, he thought that one or more definite centres were always affected; this appeared to confirm Dr. MOXON'S view that the disease was erruptive, for although one could not account for the selection, it appeared to be as definite and constant as the localised rashes which were peculiar to various other morbid states.

Mr. UHTHOFF remarked that the third stage as defined by Charcot was not one of mental failure, as he believed Mr. DAVY had said, but one of derangement of the organic functions; thus the sphincters cease to act and the evacuations are passed unconsciously. He said that in the only case he had seen he had particularly remarked an expresslon of sadness rather than photophobia. He combated, on physiological grounds, the theory proposed by Mr. AMPHLETT to account for the rythmical movements in Sclerosis.

Mr. KIDD remarked that there was one feature of Sclerosis indicated in Dr. MOXON'S report of cases which had not been touched upon, viz.:—that in four out of the eight cases, and probably in a fifth, the *onset* of the symptoms was quite sudden, though, as Mr. AMPHLETTT had said, after they had once set in, the symptoms might be very slow in their progress and liable to remissions. He also agreed with Mr. DAVY that hysteria ought to be carefully distinguished from Sclerosis, because the symptom which appeared most frequent in the early stage of Sclerosis—viz.: the occurrence of paresis of certain limbs, often getting better for a time—was far from being an uncommon one in hysteria; he quoted a case of the latter disease in support.

Mr. HICKS asked Mr. HORROCKS what was the meaning of photophobia. He considered ptosis was the origin of the peculiarity of the eyes, and thought photophobia meant squinting.

Mr. HORROCKS replied that photophobia meant fearing light literally and had nothing to do with squinting.

Meeting February 17th,

MR. LANE IN THE CHAIR.

Mr. E. ROPER read a paper on "Typhoid epidemics and their causes."

It is not every kind of decomposition that can produce Typhoid fever, it must be some specific form of decomposition which elaborates, as a specific product, the poison of that disease. To explain the formation of such a specific product, two principal hypotheses have been offered. The one assumes that the specific products of decomposition depend on the particular substances which are decomposed. To produce Typhoid fever the substances must be animal. Human excrements have the power of producing Typhoid poison. The other hypothesis is that Typhoid fever originates in the decomposition of organic substances only when these decomposing substances are mixed with the germs of the specific Typhoid poison and when these germs grow and multiply.

As to which of these hypotheses correspond best with observation, a few hints will suffice here.

Typhoid fever has never been produced by experiments with decomposing substances, nor by products of decomposition accidentally introduced into the body. In fact, daily observation is sufficient to show that the decomposition of organic substances is not of itself sufficient to produce Typhoid fever. Cities with defective sewerage are not, by any means, always visited with Typhoid. Besides the external conditions favourable to the development of the Typhoid poison, something else is necessary, and this something is the specific poison itself; this specific poison finding an appropriate soil produces an epidemic. The poison of Typhoid fever is to be looked for in the excrements of those suffering from the disease. An epidemic is often composed of a number of endemics. Groups of houses or even single houses represent foci of the disease, while houses between these are not affected (Croydon epidemic, 1876). When Typhoid fever is once established in any locality it may disappear for a long time, and then suddenly reappear without the introduction of a new case. The poison is received into the body either by the (*a*) air we breathe, (*b*) or by the water or (*c*) milk we drink.

(*a*) Windsor epidemic, 1858. Westminster School outbreak, 1848. Uppingham School outbreak, 1876.

(*b*) If we hold the dejections of Typhoid patients to be the carriers of contagion it is *a priori* probable that they become mixed with the drinking water; but the presence of the Typhoid poison is a necessary condition. Observations favor that the poison can be

destroyed by boiling the water. Experiences of infection by drinking water—

Croydon epidemic, 1875. Cases in *Lancet*, October, 1875.

(*c*) Propagation of enteric fever by infected milk—

Eagley outbreak, February, 1876. Barrowford and Blacks, December, 1876.

The real cause of every epidemic and of every isolated case of Typhoid fever is only the specific poison of Typhoid fever. If the specific poison is absent, every other evil influence may act on the population without producing Typhoid fever. A more exact study of the way in which Typhoid is propagated shows that the infection is diffused from individual privies and dunghills, and secondarily from individual springs.

The greatest predisposition to Typhoid is between the ages of 15 and 30 years. It diminishes in proportion to the distance of the age from these limits. From 1 year to 15 years predisposition steadily increases.

Mr. AMPHLETT thought the paper highly interesting. Mr. ROPER seemed to state that the vitality of Typhoid germs was so great that they might live an unlimited time. He (Mr. AMPHLETT) had but one fault to find with Mr. ROPER, who had endeavoured, apparently, to prove that newly married couples were especially susceptible to take Typhoid; any rate he had mentioned the fact of several such couples taking the disease when on their wedding tour, and had neglected to name the hotel at which they stayed; this, Mr. AMPHLETT thought, was too bad as many members present, being of a marriageable age, would doubtless prefer to avoid such dangerous places. He thought evidence shewed that the specific poison of the disease did not always come from the intestinal secretion, and quoted a case in Stockwell Hospital and also that of a Dr. Russell in support of this view. Some people still thought that decomposing matter might produce the disease, but he did not think this possible. Dr. Klein, after long investigation, had found a germ to account for it, but Dr. Creighton had proved this to be wrong and that Dr. Klein's germs were produced by the reagents he had used.

Mr. HORROCKS wondered why Mr. ROPER objected to the term "Typhoid Fever," he thought he might as well quarrel with the term "Scarlet Fever." He agreed with Mr. AMPHLETT in thinking that the poison of Typhoid might arise from putridity. He then quoted a case where several men were engaged emptying a sewer while some boys were looking on, the boys got Typhoid while the men escaped; he asked for an explanation of these facts. In connection with the question of milk carrying the infection, MR. HORROCKS said that it was only after the milk had been diluted with water that it became dangerous.

Mr. RUSSELL thought the poison of Typhoid specific, but considered it farfetched to talk of it as an animal as against a vegetable germ, since in such low stages of life the two could not be distinguished. He then dwelt on the close analogy which existed between Tuberculosis and Typhoid. The lesion in both was the same, and if the hypertrophied lymphoid tissue, which was common to both, were to ulcerate in a case of Tuberculosis he did not think it could be distinguished from Typhoid ulceration.

Mr. UHTHOFF thought Mr. ROPER'S distinction between animal and vegetable cells a very evident one. He explained the boys getting Typhoid instead of the men by their age. In epidemics the following precautions ought to be sufficient to stop their course:—(1) Burn and disinfect the excrements. (2) Boil and then filter all drinking water. (3) Boil the milk.

Mr. DOWNES thought the germs of Typhoid would only develop, so to speak, in a suitable ground. It did not at all follow because germs getting into the intestine produced Typhoid that therefore they would do the same if breathed into the lung; the necessary pabulum might, in the latter case, be altogether absent.

Mr. COLEY did not think the question of animal and vegetable cells to be more than a question of words. Is Typhoid a specific poison, or is it a certain affection of the intestines? Why should not different causes lead to ulceration of intestine as they do in cases of inflammation of the lungs? He then quoted a case of Typhoid, which lately occurred in Addison, where the fever did not develop till long after the proper time, and argued that infection from water in this Hospital could not be the cause. Men in sewers get immunity from Typhoid from being used to it, just as pathologists do not suffer from effects of their post-mortem work. He did not know of a fatal case of poisoning from a large dose of animal virus.

Mr. DAVY thought Typhoid had as much right to be termed a specific disease as any other that could be named. In numerous cases it had a well marked incubation, a more or less certain course and duration, a characteristic rash, and a definite pathology. He disagreed with Mr. COLEY that animal and vegetable poisons could not kill quickly; the poison of malignant scarletina or small-pox would kill off a patient just as quickly as most of the inorganic chemical poisons. It was unfortunate Dr. Klein's germs had been upset, especially as Mr. Simon had shown that they were the same as those found in a German well to whose water Typhoid had been traced. It was wrong, however, to say Dr. Creighton had proved Dr. Klein wrong, for Dr. Klein had found out his mistake and had himself communicated this to the Royal Society quite as soon as Dr. Creighton.

Mr. MACKERN said that our belief in the specific entity of disease was becoming less every year; the history of medicine and therapeutics showed to what an absurd extent that belief was carried in former days. He thought that more good would be got by strict attention to physiological rules and personal hygiene than by searching into organisms of which we knew little and had seen less.

The last meeting of the Session will be on Saturday, March 17th, when Mr. H. Davy will read a paper on "The pathology of Acute Rheumatism in relation to treatment." Dr. Wilks will occupy the Chair, and the names of the prize winners will be announced.

ON DUTY FOR MARCH.

House Physicians:—Coley and Kidd.
Junior House Physician:—Porter.
House Surgeon:—Lancaster.
Junior House Surgeon:—Lubbock.
Senior in Charity:—Brett.
Junior in Charity:—Finch.

DRESSERS.

For the weeks commencing:—
February 28th, Hinton (Mr. Bryant).
March 7th, Barrs (Mr. Durham).
" 14th, Bowen (Mr. Howse).
" 21st, Uhthoff (Mr. Forster).
" 28th, Shaw (Mr. Bryant).

We have great pleasure in recording the appointment of Rutherford J. Pye-Smith, F.R.C.S., late House-Surgeon and House-Physician at this Hospital, as Surgeon to the Sheffield Public Hospital and Dispensary. Mr. G. E. K. Thorpe, a former student here, also belongs to the Staff of this Institution.

It is with great satisfaction that we record the recent election of Mr. Bryant as Corresponding Member for London of the Surgical Society of Paris. Mr. Lister was at the same time elected for Edinburgh.

GUY'S HOSPITAL GAZETTE, *MARCH*, 1877.

"COMING events cast their shadows before them," and examinations are no exception to the rule. The evidence of the near approach of the College "Primary" is to be seen in the busy aspect of the dissecting room. "Subjects," in a condition of more interest to the anatomist than the artist, are plentiful we are glad to say, while individual "parts" show that every possible inch of tissue, which men are liable to be "got on" at the College, has been the subject of careful examination, and more than ordinary interest. A deep dissection of the sole of the foot is now regarded in the light of the relative size of the plantar nerves, and of the number of muscles supplied by the external plantar, the possibility of a wounded deep plantar arch and troublesome hæmorrhage therefrom is a question for the future evidently; a deep dissection of the parotid region is viewed in relation to a famous "pickle" at Lincoln's Inn Fields, rather than with regard to the excision of a tumour in that quarter. Besides this general work, the walls near the door are simply bristling with notices of classes and demonstrations, and, what is much to be commended, notices of written examinations to be held in the Practical Physiology room. All this, then, means work, and work much to the point; especially is it so in the case of the classes and demonstrations, for they are valuable in giving the teachers a better acquaintance with the actual amount of knowledge possessed by the would-be candidates, and it also gives the latter practice in answering concisely *viva voce* interrogations. The written examinations are a good test of the candidate's power of systematising and arranging his knowledge on paper so that he can make the most of it; by them can be seen how far the "lucid order and sure grasp" in the race of knowledge have been attained. Increasing experience, both of student nature and of examinations, has shown the necessity for this system of teaching, for some of us can remember when demonstrations only came on during the last month or so of the session, while written examinations never came on at all. This new system has not been tried long enough yet to enable any comparative statistics of failures to be made, but the subject will, no doubt, be one of interest at a future time; now, however, it is for us to congratulate intending candidates that access to anatomical facts may be gained by so many paths. Yet, knowing that the vast majority of men come up without any idea of the real nature of an examination, and with, perhaps, but few ideas on learning medical science in general, we may be pardoned if we attempt to offer a word of warning. Dr. MOXON, in his late Hunterian oration, showed most conclusively that knowledge is *not* power when it tends merely to the accumulation of "fact-heaps;" yet how difficult this lesson is to learn in the case of anatomy, which is apparently but a heap of facts when taken in relation with an examination in that subject! It is so true, that the man who knows the greatest number of anatomical facts is generally the man who will do best at an anatomical examination; yet the idea that we wish to convey is, that the mere passage of the first College or first Fellowship is not the *summum ultimum* of all our hard study of Ellis and Hermann.

If we may be allowed to become somewhat physical we will illustrate our meaning by reference to a lever of the first order—the *weight* is the end to be attained, the fulcrum is our collection of well-ascertained facts, the *power* is the inference that we draw by the process of induction from those facts. Anatomy, *per se*, is a mass of facts; when taken in relation to physiology, comparative anatomy, surgery, pathology, and medicine it becomes a power to be felt both by doctor and patient.

Of course, examinations must be passed, and we trust that the high percentage of last year may be even surpassed this April; but our object now is to warn successful candidates against the tendency there is to disperse the "fact-heaps" that have been so laboriously collected as soon as possible.

Turning now to the more practical side of the question, thereis much to encourage our April men. In the first place they have the noble example of the January men, who came back from the ordeal without one man missing, and the trial will not be more severe, or the battle greater next month; again the new system of

examination—A separate board of examiners in Anatomy and Physiology, and the use of marks in place of vague and indefinite expressions, both are in favour of the candidate; the character of the questions asked now is different to what it was, the questions being far more definite and concise, and yet, strange to say many seem to think the papers "stiffer" on that account. Now, clearly this is a mistake, for there is nothing more embarrassing in an examination room than to be uncertain of the *exact* meaning of the question, and therefore nothing more likely to create a difficulty. Certain it is that a definite question requires a definite and accurate answer. But accuracy ought to be the guiding principle during the learning of facts, and if this has been made a rule during the preparation, accuracy in answering will not constitute a difficulty when the testing time comes. More attention is paid to Physiology now than was even the case four or five years ago; it is not now possible to pass having merely scraped through the Physiological questions in the paper, a *viva voce* in Physiology in now a *sine qua non*, and the result must be far more satisfactory both to examiner and candidate; our knowledge of physiology is not now merely judged by our answers to two questions.

We make these few remarks at this time because we believe these few weeks preceding the 1st College to be an important period, and perhaps they will not be out of place on that account.

IN another column our readers may see a report of Prof. LISTER's speech to the Edinburgh students on the occasion of the presentation of the memorial begging him not to go to London, where he had never been asked to go. Truly the great northern light has shone on us poor darkened mortals in London, and has revealed to us the melancholy fact that our system of clinical surgical teaching is a *mere sham*, and yet more than that, it is also our own fault—it is *slurred over*! How becoming then it would be for all the teachers of surgery in London to go into sackcloth and repent in dust and ashes, and it would only be decent for the leading ones to resign at once and go across the Tweed to learn how to do it, *if it were only true*. But it is not true, and London professors of surgery have too much clinical work to do to be able to afford time for two lectures a week for eight months.

When the Shah of Persia met the Emperor of Russia for the first time he is reported to have said to that sovereign, "We are pleased with you, you may go on reigning." We hear from Edinburgh that we are successful in our clinical medicine teaching, in some schools at least, and we suppose then that we may go on teaching medicine; but, according to Prof. LISTER, we are being deluded if we think we are learning surgery in any Metropolitan school. It is vain for us to tell of the immense surgical practice of even three of our hospitals, viz., St. Bartholomew's, London, and Guy's, for we are told that the magnificent opportunities of demonstrative teaching presented by clinical teaching are, to a great extent, neglected. But what are the *facts* of the case? It is just what an old Guy's man, and a former H.P. here, writing from Edinburgh to us describes, "It is not easy to imagine a more complete *curriculum* in practical surgery than is open to a Guy's man;" and this is the only fair inference that can be drawn from studying a list of appointments such as this:—Assistant Surgeon's Clerk, Surgical Ward Clerk, Dresser in the Surgery, Assistant Surgeon's Dresser, Surgeon's Full Dresser, Dresser in the Eye Wards, Aural Surgeon's Dresser, House-Surgeon; while, according to our correspondent, "An Edinburgh man has two surgical appointments open to him, namely—*first*, a Dressership with a fixed number of about five beds, without any residency and lasting for five months; *second*, a Clinical Clerkship with the duty of giving chloroform at operations. Next, *cum largo intervallo*, a House-Surgeoncy *if* he can get it. There is no special out-patients' department, each surgeon seeing in the ward such out-patients as may turn up daily; the number of out-patients is about equal to number of in-patients." He then goes on to say that "As far as lectures go we are behind Edinburgh, for they have a Chair and Regius Professor of Clinical Surgery, with two lectures a week eight months out of the year."

The evidence that we have drawn alone from Guy's

Hospital is in itself conclusive, but it becomes overwhelming when we take into account the other two large hospitals, for we must remember that the Professor condemned the whole surgical teaching in London as one great sham. The clinical lectures at Edinburgh may be good (very good, indeed, they are), if peculiar, but for practice, actual familiarity with injured flesh and blood, which is the *summum ultimum* of all surgical training, it requires no argument to show that London, from its very circumstances, stands unequalled.

We cannot suppose that Prof. LISTER was thinking of his own method of teaching when he said that there "was nothing in London which he would consider good enough to call him away." We think we have heard a few good clinical lectures in our theatres, Mr. SAVORY has also been known to speak very much to the point at Bartholomew's, while Mr. JONATHAN HUTCHINSON'S fame as a clinical teacher has reached further north than "Arthur's Seat."

THE VALUE OF THE PRELIMINARY SCIENTIFIC (M.B.) EXAMINATION OF THE UNIVERSITY OF LONDON.

BY AN UNDERGRADUATE.

Of late years there has been much discussion concerning the value of Natural Science to the practical physician. Mr. Christopher Heath in his introductory address delivered in the University College, in October, 1872, says, "Of late years a horrible invention has been called into existence termed the 'Preliminary Scientific Examination,' at which candidates for a medical degree are submitted to the same tests as candidates for a degree in science. Now mechanical and natural philosophy may be, for aught I know to the contrary, the daily pabulum of that extraordinary and almost unknown animal, a Bachelor of Science, but certainly it has little to do with medicine."

I believe that a distinguished physician of our own hospital considers that being a scientific biologist is hardly compatible with, or at any rate conducive to, being a practical physician.

In the course of my student career I have received advice from various able physicians, who have urged upon me the necessity of work in the wards from the first day of entry at the hospital; they have said, "live in the wards, and gain your knowledge not from books, but by close bedside attendance, using all your powers of observation, of touch, sight and hearing, and carefully watch all the phases of disease."

Now that I have passed my first M.B. examination, I find that I am able to follow this advice to a certain extent, but not before. Suppose that one enters the hospital fresh from School having just matriculated at London; the knowledge of having to go up for the Preliminary Scientific in a year's time is constantly before one, lectures innumerable have to be attended, the intervals during the day are filled up with attendance in the p. m. room, the out-patient departments, the wards, and the dissecting room; hardly any reading is possible during the day and in the evening one is too much exhausted. What happens? Loss of health, being plucked at the Preliminary Scientific Examination, dissecting one part badly, blocking up the out-patient room without deriving the slightest benefit from being there, etc. Now, it appears to me, that all these difficulties would be obviated by not entering the hospital until the Preliminary Scientific has been passed, if this was done I believe the Examination would be of the greatest value to many students.

What would have very great effect upon Students regarding this would be, if the subjects of the Entrance Examination at Guy's were the same as those of the Preliminary Scientific.

Many Medical Students leave school early, passing their Matriculation Examination at London at the age of 16. What is the state of the mind of many of them? Bewilderment. In order to pass such a formidable test as the Matriculation at that age, all their time has been spent in reading condensations of the various subjects, such as the histories edited by Dr. Smith; they are often, as has been frequently remarked, better up in the histories of Rome and Greece than that of England, and in the heathen mythology than the Christian religion; the meaning of hardly anything that is learnt is known, it is merely a lesson which has to be learnt in order to keep high up in one's class or some such reason. With a mind like this, what a boon it is to have a year to let it expand and enjoy the beauties of Nature and the wonders of Science before the real duties of life are begun.

What an interest in all around the study of Botany and Zoology infuses! The study of life is thus best commenced, beginning with the lowest and terminating with the highest—the study of human life. Then to know the workings of the natural forces, gravitation, heat, light, electricity, chemical affinity, etc., gives an impetus to the intellectual powers that few other subjects could. Thus I think the Preliminary Scientific Examination instead of being called 'a horrible invention," may be called a delightful one.

EXAMINATION NEWS.

Royal College of Physicians.—At the last examination for the licence, Messrs. L. H. Stevenson and R. Bevan, of this Hospital, obtained the L.R.C.P.

Indian Medical Service.—Mr. D. Elcum, M.R.C.S., passed 22nd in the recent competitive examination for Netley.

Apothecaries' Hall.—Messrs. P. Howell and J. H. Poland have recently obtained the L.S.A.

Examination questions.—The following are the papers which were set for the last L.R.C.P.

MEDICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF MEDICINE.

INCLUDING THE PRINCIPLES OF PUBLIC HEALTH.

1.—Give the precise boundaries of Cardiac dulness on the walls of the Chest during health; state the position of the valves of the Heart, and also in what conditions the dulness is lessened or increased.

2.—Describe the sequelæ of Scarlet Fever, their usual ulterior effects, and the manner of treating them.

3.—Give the clinical history of a case of Acute Pneumonia, and state the several varieties of the disease.

4.—Give the symptoms, diagnosis, and treatment of Acute Catarrh of the Bile Ducts.

5.—What are the causes of Hæmaturia? How would you distinguish the diseases having this symptom the one from the other, and how would you treat the respective diseases?

6.—What are the symptoms of Chronic Poisoning by Lead, and what are the usual agents and channels by which it is introduced into the body?

MIDWIFERY AND THE DISEASES OF WOMEN.

1.—How would you distinguish a case of impending Abortion from Menorrhagia?

2.—Enumerate the principal solid substances that may be expelled from the Uterus. Point out briefly how they may be distinguished from each other.

3.—A woman aged thirty, not having menstruated for three months, is seized with violent bearing-down pains, and then has Retention of Urine. The Abdomen is very tender to touch, and a tense swelling marked by dulness on percussion, and very prominent, rises as high as the Umbilicus. How would you proceed to make a diagnosis? Discuss the several causes that might lead to the conditions described.

4.—What do you consider to be the normal duration of the Second Stage of Labour in a Multipara? Mention the principal causes of delay in the second stage, and point out the limit beyond which delay may be dangerous to the mother or child.

5.—Describe the shape and size of the Uterus immediately after perfect and complete expulsion of its contents at the end of labour.

MATERIA MEDICA AND CHEMISTRY IN ITS APPLICATIONS TO PATHOLOGY, PHARMACY, AND TOXICOLOGY.

1.—Describe the different kinds of Electricity. In what diseases, and how are they used?

2.—What are the remedies used for Coughs? What are the indications for each?

3.—Give a general account of the actions and uses of three or four cholagogue remedies (mineral and vegetable), stating the dose and theory of the *modus operandi*.

4.—Describe the remedial uses of Acetate of Lead, the effects of its abuse, and the means of correcting them.

5.—"Acidum Hydrochloricum" contains 31·8 per cent. by weight of Hydrochloric Acid Gas. What quantity of common salt must be used for the preparation of one pound of acidum hydrochloricum?

6.—Give a general account of the process by which coal gas is prepared, of what does it consist, and what is formed by its combustion? What chemical tests would you apply to the air of a room to ascertain its purity?

7.—What is the composition of Corrosive Sublimate, of Calomel, of Oil of Vitrol, and of Aqua Fortis? What is the action of Ammonia on these bodies, and by what tests may they be recognized?

8.—What is the general composition of animal fats, and what changes do these bodies undergo when acted on by caustic alkali?

The following questions were asked at a recent examination for the licence of the Apothecaries' Hall:—

MEDICINE.

1.—Explain the causes of the physical signs in the various stages of Phthisis.

2.—Sketch a case of Asiatic Cholera with its treatment; what are its sequelæ and their treatment?

3.—Give the usual history of a case of Cirrhosis of the Liver; its prognosis and treatment.

PATHOLOGY.

What are the pathological changes in the blood?

What are the uses of the Clinical Thermometer?

THERAPEUTICS.

Enumerate and describe the action of the various remedies for Hæmorrhages—active and passive.

MIDWIFERY.

1.—What are the measurements of the Female Pelvis? What deviations from them would require the use of instruments?

2.—What are the indications for giving Ergot? Give its preparations, their doses, and mode of administration.

3.—Give the diseases with their treatment which arise during dentition.

TOXICOLOGY.

1.—What are P.M. signs of drowning? Under what circumstances may these signs be absent after submersion?

2.—How would you purify a room or house after infection?

3.—Give the antidotes and tests in poisoning from Arsenic, Corrosive Sublimate, and Prussic Acid.

A *Vivâ Voce* at the Royal College of Surgeons (membership), January, 1877.

MR. LE GROS CLERK.

What are the symptoms of a fractured rib? How would you proceed to examine that man for a fractured rib? How may such an injury be caused? Are ribs ever broken by direct violence? If so, what may be the complications and why? What would lead you to suspect that the lung was wounded?

How would you treat a man with cancerous stricture of the rectum? Supposing the man was becoming worn out with the pain, discharge, &c., what would you do? On which side would you perform colotomy and why? Where would you make your incision? (To be marked with blue chalk). What are the structures cut through? Is the external oblique muscle tendinous or muscular at this part? What is the guide to the colon? How would you proceed with the operation? Can you see or feel the kidney during the operation?

What are those two lines? (Sternal origins of sterno-mastoids). Are they muscular or tendinous? What structures lie between that point (one inch above sternum) and the spine? Put your finger over the interval between the thyriod and cricoid cartilages. Is the cricoid cartilage broader in front or behind? Of what structure is the crico-thyriod membrane?

MR. SPENCER SMITH.

What is the matter with that man lying on the couch? You may ask him any question you wish. (Syphilitic periostitis of both tibiæ). How would you treat him? What is the matter with this man? (Strumous disease of one of his finger joints). Another patient with scrofulous testicle with abscess,—What is it? What does it feel like? (Nodulated and not very hard). What may be the result of abscess of the testis? Another case—funicular hernia, with a varicocele on the same side (left)—What is it? Is it oblique or direct? How do you diagnose it?

PATHOLOGY.—MR. CURLING.

What is that? (A rib that has been fractured). How are ribs fractured? If by direct violence, with what complication? How do they unite? What is that preparation? (A tumour connected with middle phalanx of finger—enchondroma). What tumours connected with bone are there? Is a finger a common seat of enchondroma? Do they grow anywhere else? (Testicle, parotid, and mamma). Do they recur after excision? A calculus,—What kind is it? (Oxalate of lime). Another—(lithic acid). Are lithic acid calculi usually tuberculated on the surface like that? (This stone was covered with a number of small raised spots). Another stone (phosphatic)—What was the probable nucleus of it? Did it form in the kidney or bladder?

MR. ERICHSEN

Shown a tibia and fibula together, the former fractured and badly united in the lower third, the latter fractured in the upper third. Is a tibia usually broken there? Is a fibula usually broken there? How should you think that accident was caused? Is it a good result? Should you fancy it had been compound? How would you put up a simple fracture of these bones? If compound, what would be your treatment? What would justify you in amputating?

What is that preparation? (An artery with a plug in it). What may cause an artery to become plugged? Which do you know most about—arteritis or phlebitis? What are the symptoms of phlebitis? What may follow?

We regret that through an omission the names of the successful candidates in January 1st College were left out in the last *Gazette*. Thirteen went up and all passed. The following are the names:—Messrs. A. J. Burton, J. T. Wilkinson, W. Gray, Russell, Pilkington, Fooks, Howard, Hawkins, Hine Haycroft, Leigh, Philips, G. H. Jones, Parke, W. Gray Burton.

NOTES OF THE MONTH.

A Week's "Take-in."—As doubtless many old Guy's men and others may be interested in knowing the amount and character of the surgical practice at this Hospital, we publish an analysis of one week's "Take-in" in the early part of last month.

Fractures and dislocations.—

1. Fractured tibia and fibula (simple), 2.
2. Do. patella (transverse), 2.
3. Do. femur (simple), 2.
4. Do. ribs, with wounded lung, 2.
5. Do. jaw (lower), 1.
6. Do. radius, also head injury, 1.
7. Dislocation of cervical spine (death in 39 hours), 1.
   Do. double, congenital of both hips, 1.

Tumours.—

Carcinoma of breast.
Lipoma of back.

Diseases of bone.—

Caries of tarsus.
Necrosis of lower end of fibula.

Miscellaneous.—

1. Cut throat, between hyoid bone and thyroid cartilage.
2. Gunshot into left orbit, excision of eye (death).
3. Cleft palate.
4. Stricture and perinæal abscess; Cock's operation.
5. Ulcer on leg.
6. Secondary syphilis, mercurial palsy.

PROFESSOR LISTER ON CLINICAL TEACHING IN LONDON.—We recommend a calm perusal of Professor Lister's views on the state of clinical teaching of surgery in London, as reported in the *Scotsman* of February 23rd; they were promulgated in answer to the recent address of the Edinburgh students.—"As I said to you at the last lecture, there has really been no actual offer made to me by the authorities of King's College; and such being the case, I feel it an exceedingly difficult thing to say a word on the matter further than this, which is very much what I said on the last occasion, that there exists nothing in London at the present time which I should consider good enough to call me away from this school. (Cheers.) I said, gentlemen, on entering upon my office here, that I believed that this chair, if properly conducted, as it had been by my lamented predecessor, was more potent for good than any other chair in the medical *curriculum*; and I hold to that opinion. (Applause.) We have in surgery, as compared with physic, the extreme advantage that, whereas the disease with which the surgeon has to deal is the same in essential nature as that with which the physician deals, yet, while th physician must walk comparatively in the dark and act from inference rather than from direct observation, the surgeon has the opportunity of observing what he deals with in the actual living flesh and blood. Now, gentlemen, I say that this gives an opportunity to clinical surgery as a means of instruction, if properly conducted, which no other chair in the *curriculum* possesses. But if I turn to London and ask how instruction in clinical surgery is conducted there, I find that, not only according to my own experience as a London student—which I once was—but also from the universal testimony of foreigners who visit there and then come here, it is, when compared with our system here, a mere sham. (Applause.) Clinical medical teaching is in various London schools exceedingly well and ably conducted; but that in clinical surgery is simply neglected and slurred over in London. And, therefore, even if the too flattering article in a certain medical journal holding out to me fame and fortune and so forth—(laughter)—were more reliable, and if I were certain—and I need not say how far indeed from what would be the fact the supposition is—that I should have the topmost position in London in private practice, and have to teach clinical surgery as it is taught in any London school at the present time, I would certainly not go to London." (Cheers.)

We regret to have to announce the death of Dr. Lewis Edwardes, which took place on board H.M.S. Volage, on the 13th ult., from the effects of cyanide of potassium, which he took in mistake for a sleeping draught. Dr. Edwardes was fellow student with some of our Staff at this Hospital, and his picture may be seen in one of the groups in the Rooms.

Football.

FIRST TIE FOR THE CHALLENGE CUP.

GUY'S *v.* ST. GEORGE'S.

Our first match for the challenge cup was played at the Oval, on Thursday, February 15th, and was witnessed by a large number of spectators. St. George's won the toss and elected to play with the wind. For the first half-time the game was mostly carried on by the forwards and Guy's scored 4 touch-downs to nothing. Soon after changing ends, Stokes made a brilliant run and obtained a try, but the place, by Pearson, was a failure. The ball, being again kicked off, was quickly taken into dangerous proximity to the St. George's goal, and, after numerous scrimmages on the goal line, Boswell obtained a try, which Gray converted into a goal. Very soon after this Jackson secured a third try, the place kick again being a failure. Directly the ball was restarted, Stokes made a splendid drop at goal from the middle of the ground, the ball going about three feet below the crossbar. Soon after the ball was again set in motion Gray very nearly succeeded in getting in, being collared just on the goal line. Just before time was called Stokes dropped a goal. The match thus ended

in our favour by two goals, two tries and several touch-downs to nothing. Besides those already mentioned, Pearson played well, and of the forwards Keer, Boswell and Fraser played uncommonly hard. For St. George's, Jennings was most conspicuous.

The following played for Guy's:—A. W. Pearson, E. Penny (backs), L. Stokes (three-quarter back), W. G. Gray (capt.), A. H. Jackson (half-backs), J. C. Keer, J. A. Fraser, J. Boswell, H. Liddell, R. S. Taylor, J. Rees, Q. R. Veitch, D. D. Roberts. F. S. Wilkinson, J. Lister (forwards).

GUY'S *v.* RICHMOND.

This match was played at Richmond, on February 10th, and ended in a win for Richmond by a goal and two tries to nothing. Gray kicked the goal for Guy's. Evanson ran in twice for Richmond.

GUY'S *v.* GIPSIES.

On Saturday, February 17th, we played this match at Putney, and lost by two goals and a try to nothing. Gilbert and Boswell worked hard for the Hospital.

GUY'S (second fifteen) *v.* ST. THOMAS'S (second).

This match was played on February 10th, at Blackheath, and resulted in a win for Guy's by three tries and four touch-downs to nothing. The Guy's forwards played well together, and kept the ball constantly in their opponents' quarters, especially during the latter part of the game. For Guy's, Shepherd and Long were conspicuous, while the drop-kicking of Burroughes was very effective. For St. Thomas's, Cockell, Atthill, and A. J. Harris played well.

Guy's.—Green (capt.), Atkinson, Milligan, Chubb, Cockell, Whyte, Pierson, Edwards, Troth, and Anderton (forwards), Shepherd (three-quarter back), Messum, Long (half-backs), Fasken, Burroughes (backs).

Correspondence.

TO THE EDITOR.

SIR,

I must first apologise for taking up even a small space in your valuable journal, especially as to many this may seem but a trivial matter, but to me, with undoubtedly many others, it appears important for the well-being of our Hospital.

It being given "that Guy's men are to be known as such in the outer world from their practical knowledge;" it being given also "that not only does 'practice make perfect,' but that practice teaches;" whence, would I ask, is a moderately good Guy's man to obtain his *practical* knowledge of *surgery* in many of its every-day bearings? To wit, the setting of fractures, reduction of dislocations, &c., &c.

I am glad to say the entries at Guy's almost head the list of Metropolitan Schools (say from 90 to 100 or more per annum). Of this number, I will admit, many fail *to do anything*; but looking at the reports of the Council of the College for the last four years (1872—1876), I find on an average 63 Guy's men have qualified annually during that period. Now, for convenience of figures, we will strike off 15 of this number, some of whom may not live, or for various reasons fail to practice; this leaves 48 students—good or moderate—to be turned into the world chiefly, I presume, as country general practitioners.

Our surgeons' dressers number 24 annually (*vide* Prospectus), or half the above number; these alone are allowed the privilege of setting fractures, &c.,—in other words, of having patients under their especial care. It is well known that our assistant-surgeons have but few beds, amongst which alone many of their dressers have to gain practical experience;—in other words, I would ask whence are the remaining 24 men (or one-half) to obtain the necessary information of "how to set a fracture?"

Forsooth! fractures are common enough in country practice.

It is true we have lectures—common and clinical—and practical surgery classes, all of which deserve the highest praise, but whence that practical knowledge on the *living subject* which alone can give confidence in general practice. Surely this is hard, not only to the student anxious to acquire the necessary skill and tact, but also to the general public who suffer from the inexperienced surgeon.

Now, Sir, I do not mean to say that the appointments are not given to the best men, far from it, but what is to become of the good-moderate men (24 at least in number) who have failed to obtain their dresserships. Good-moderate men, I say, for there be many who from various reasons have not undertaken the University Curriculum either at London, Cambridge, Oxford, or elsewhere, the first F.R.C.S., Eng., or even have not passed their first M.R.C.S. as soon as might be. What matter this if they've worked well and wish to be turned out as good practitioners? These I term *good-moderate* men for the sake of those who style the above *good* men.

This may appear to you, as it does to me, one of the very few, if not evils, unlucky points at Guy's. Why not then, I would suggest, increase the number of beds to assistant-surgeons, and allow *their* dressers to obtain *some* skill at least in the points above-named? This, to my mind, could best be done by the apportioning of a few beds in the Accident wards to the assistant-surgeons and their dressers.

Pardon me for writing to this length, but the importance of the subject may be my plea; for I think you will agree that many men *must* leave the Hospital not having gained experience in some of the most necessary items of their profession.

Enclosing my card,

I hope to remain,

"One who has not been refused his appointments."

P.S.—Is it not true that at St. Bartholomew's comparatively more men obtain their higher appointments? Which include the above cases, and thus they obtain that *true practical* experience (which is so essential to a good practitioner) rather than that gained on the dead subject only. This may be one answer to the question often put to me of late by old Guy's men, "How is it Bart's out-number you in entries?"

Guy's Hospital, S.E.,
February 27th, 1877.

TO THE EDITOR.

SIR,

Those of your readers who were privileged to hear Dr. MOXON's scholarly address at the Hunterian Society, or who have had the benefit of a quiet perusal of the abstract in the pages of the *Lancet*, must be painfully aware that he has struck at the root of a great difficulty, I might say evil, and one which it is the tendency of the day to steadily increase. There can be no doubt upon one point; the supreme object of our medical schools and examinational boards is to turn out annually a body of men who shall be, in a necessarily limited time, best instructed in the diagnosis of disease and in the application of such remedial treatment as is at our disposal; nay, I may say their *raison d'être* consists in this. When, however, we come to the examination of our present system, whether we judge by results, or from *a priori* considerations of what the effect of the ordinary medical student's training would be, we cannot, I think, but come to the conclusion that we have not got hold of the best means to attain the object in view. There are two directions in which it is possible we go wrong; the fault may be either with our examinational or with our educational system, or possibly with both. Is the latter the reflex of the former? If so, by finding out where we go wrong, the mistake being rectified in the one will apply the necessary corrective to the other. Judging by results, I think we cannot but conclude that, whatever may be the defects in the training and teaching of the student, a good

many of these are the consequences of the sort of knowledge a man is expected to possess.

The great object of emulation of most of the schools now a days is to get the largest entry. Pass and pluck list are annually published with the names of the colleges ticketed to them. It is supposed that the best list at the College will go largely to obtain the best entry; at all events we strive might and main to obtain the one and hope that the other will follow, The average student's object is mainly to "get through;" Does the man who haunts the dissecting room or the wards stand the best chance? The result of all this is one great system of "coach and cram" from beginning to end.

Ask a man a question of fact, and he counts you off the answers on his fingers, but ask him one that necessitates his reasoning faculty, in nine cases out of ten he is *non plussed*. Now, the question arises, how far the examiners are to blame for this, and I ask again who stands the best chance with him, the man of facts or the man of reason? In round numbers, 90 men enter annually at Guy's and the same at University College, and these men may reasonably be expected to bring with them the same amount of convoluted grey matter. Guy's has about three times the opportunity for bed-side study that University College has; most of our candidates for the second M.B., London, have taken full advantage of this, and held all the clinical appointments, yet, year after year, the University scholar in medicine hails from Gower Street. Where is the fault? It is not a question of men, it certainly is not one of teaching. Is ward work time wasted for the second M.B.? Another point; examiners are but human, most of them have pet ideas of their own, and if I were examined by a given physician I should stoutly maintain that granular kidney was a general disease, and casually mention that other physicians held a different view. How does this accord with the University Calendar; do we find that the college which furnishes most examiners gets most of the honors and passes the largest average of men, or is there any reason for believing that exhibitions have any tendency to follow examiners? But I have wandered from my text. One of Dr. MOXON'S points is that in the studies which engage the student's attention during his first two years, their utility is lost sight of; a man is taught anatomy and physiology as individual sciences, without reference to their application; he is at least as, if not more, likely to know that the nerve to the subclavius communicates with the phrenic as the relations of the femoral artery; or, as the lecturer put it, he may know most accurately the conditions of digestion, and yet has not the slightest clue as to the cause of a dyspepsia; and I cannot but think our educational system must plead guilty here. Another point was that, whilst two years are thus given up to the sciences, he is but three months under the eye of the clinical tutor; but, if I may humbly venture an opinion, it is not that the former period is too long to obtain a knowledge of these sciences, especially if the teaching of them were modified in the way he suggests, but rather that three months is far too short for supervised clinical work.

It may be asked for what reason I have troubled your readers with these disjointed remarks, even though I am feebly following the footsteps of a great leader, especially as I suggest no remedy for the faults alleged; but to these I will say, that the humble mechanic will find out that the machine is working badly, it may be even at what point, but it requires the skill of the engineer to set it right.

Yours obediently,

NEMO.

APPOINTMENTS MADE FEBRUARY 24TH, 1877.

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Obstetric Out-Patient Clerks.—Hart, R.A.N., Morton, Parry, Wells, Harris, Reynolds, Ross, Cox.

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Sharp pain in one, no feeling in the other;
In one, the patient hoping pain to smother,
Calls pressing, tossing, writhing to his aid:
No movement in the other can be made.

1 This muscular contraction tries me sadly;
I had it in the cholera most badly.
2 The nose, a filthy smell, dead bone your notion,
Try syringing some medicated lotion.
3 Epiphora, the sac may be diseased;
By slitting the canal it might be eased.
4 The patient's skin, and conjunctiva too,
Both evidently have a yellow hue.
5 Cutaneous nævus, red hot iron; no,
For the galvanic well succeeds you know. M. L.

SOLUTION OF DOUBLE ACROSTIC.

In the *Gazette* of February, 1877.

S y n c o p E
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P h l e b o t o m Y
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STATISTICAL REPORT OF LYING-IN CHARITY FOR JANUARY, 1877.

Number of women attended				238
Recovered	236			
Died	2			
	238			
Women attended in 1st confinement				32
„ „ 2nd „				32
„ „ 3rd „				27
„ „ 4th „				27
„ „ 5th „				32
„ „ 6th „				36
„ „ 7th „				14
„ „ 8th „				12
„ „ 9th „				11
„ „ 10th „				6
„ „ 11th „				4
„ „ 12th „				1
„ „ 13th „				2
„ „ 15th „				1
„ „ 18th „				1
				238
Children at full time.				
Males alive...	116			
Males dead...	5			234
Females alive	110			
Females dead	3			
Premature children.				
Males alive...	5			
Females alive	2			8
Females dead	1			
Abortion...				1
Total number of children				243
Alive	233			243
Dead	10			
Presentations.				
Vertex		231		
Vertex and feet		1		
Brow		1		
Breech		5		
Feet		3		
Transverse...		1		
Abortion in membrane		1		
		243		
Operations.				
Forceps	1			
Complete Version	1			
Partial Version	1			
	3			
Externs attended.				
Mr. H. W. Campbell				82
Mr. W. A. Phillips				62
Mr. C. Collins				48
Mr. A. Taunton				43
Casuals...				3
				238

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Clinical Surgery.

HYDROPHOBIA. By Mr. Howse.

Mr. Howse commenced his lecture by referring to the apparent increase in the number of cases of Hydrophobia of late years; this he inclined to view as a result of an increasing desire on the part of the populace to keep dogs, which, he thought was an effect of civilisation, the dogs were kept more or less in an unnatural way, and therefore more prone to get the disease. But it must be remembered that the disease can be communicated by other domestic animals, notably the cat, which by some observers is said to be more dangerous than the dog. When a patient comes in with hydrophobia, the system has already been infected six weeks or more, and as no case of true hydrophobia has ever been known to recover, the treatment of the wound must be of the greatest importance in the first instance. Should we cauterize *every* dog or cat bite? for children are being continually scratched or bitten by cats. The question will probably become a medico legal one some day. Was the wound cauterized? Evidently then there ought to be some principles on which to go, and Mr. Howse laid down the following rules:—

1.—If a dog not hydrophobic bite on a part of the body covered with clothes, and the fang penetrate the the blood bearing tissue after having traversed the clothes, then simple cauterisation is enough.

2.—If a dog be hydrophobic and bite on covered part of body, even then simple cauterisation is enough.

3.—If a dog not hydrophobic bite an exposed part, *i.e.* the part not covered by the clothes, of the body, then here again simple cauterisation will be enough.

4.—If a dog be hydrophobic and bite an exposed part, then excise by the knife, and afterwards cauterise.

In rule 1, cauterisation should be done if only to restore peace of mind to patient.

Cauterisation. In all cases it is not safe to use Nitrate of Silver alone, because as soon as applied a layer of Chloride of Silver is formed from presence of Chloride of Sodium in the tissues, and the layer so formed prevents the caustic action of the Nitrate of Silver from proceeding deep enough. Mr. Howse considered a stick of *Caustic Potash* to be better than ordinary caustic, and it is equally convenient, it should be thrust well into the bottom of the wound. In rule 2, it is better to apply strong Nitric Acid first, and follow it by application of Nitrate of Silver.

Mr. Howse then again insisted on the importance of the surgical treatment of the wound, as soon as possible after committed, and related two cases where the hydrophobic symptoms did not develop till 2 years and 25 years respectively after the bite.

CASE OF SUPPURATIVE PERITONITIS SIMULATING HERNIA.

A man, æt. 40, was taken ill last December with symptoms of small pox, the eruption was not well marked, consisting only of a few scattered vesicles; he appeared to do well, and rapidly improved. But on the 23rd of December, he was admitted into Naaman severely ill; there was a swelling in his groin, which had been diagnosed as hernia outside the hospital, this swelling was tender and irreducible by manipulation, it was attended with constipation, but *not with vomiting*, the abdomen was distended and tympanitic, pulse wiry, and aspect peritonitic.

The swelling being irreducible, the ordinary oblique hernial incision was made over it, but on opening the sac, a quantity of very fetid gas escaped, and it was at once thought that the intestine had been opened, the walls being adherent to the sac, in the vesicle of the sac however were found curdy bits of stinking pus, and the cavity of the so called sac, could not be braced far towards abdominal cavity; it was clearly then not a case of strangulation of bowel at an external orifice. The cavity of the sac was well washed out with Carbolic lotion, and opium freely given, and no further operation was done. The man for several days hung between life and death, becoming exceedingly prostate and wasted, but notwithstanding the appearance of a large bedsore, he went on to a recovery, and, when shown at the lecture on March 14th, he appeared fairly well and hearty.

In reviewing this very remarkable case Mr. Howse said that the diagnostic point was the absence of vomiting, and it was that which guided him to no further operative interference. It should be remembered, however, that vomiting sometimes occurs in peritonitis and it may even become stercoraceous, but we should not be tempted to open up the wound again, in cases of strangulated hernia because of the persistence of vomiting, for the presence of gangrenous bowel may still keep up the peritonitis. The gas in the above case was free, and formed from the decomposition of the tissues due to the variolous poison. The man recovered because he was able to survive the effects of the specific poison, which always runs a definite course and lasts only a certain time.

CASE OF STRANGULATED FEMORAL HERNIA.

The case was one of an old woman who had had a femoral hernia for some years. One day at dinner she eat something which disagreed with her, and symptoms of strangulated intestine came on at once; *three days* after, she was seen by Mr. Howse, who operated at once and found the intestine already reddened and gangrenous; the patient died. The mistake here was

the delay; *twelve hours* should not be allowed to elapse after strangulation has occurred, and recourse should be made to operative measures, and this is especially necessary in old people.

Mr. HOWSE then went on to say that a future rule of hernia will be some day—when the instrument maker is unable to make a truss which shall properly keep up a hernia, then cut down on the tumour and remove enough omentum to allow a truss to be made so as to work properly, if the hernial sac be healthy, and the case treated thoroughly antiseptically, then he had no hesitation in saying that there was positively *no danger* in the operation of the patient.

TWO CASES OF VENESECTION.

With the permission of Dr. Wilks, and Dr. Taylor, under whom the patients were, I give below the notes of two cases which were examined in the post-mortem room a few days ago. They are cases very similar in their nature, not rare, but interesting, on account of the example they afford of a plan of treatment which is rather uncommon now-adays, or at least less common than it must have been 20 or 30 years ago. The fact that they were both examined in the post mortem room soon after the above treatment does not speak very highly for its success; however, in both cases some relief was given, and more might have been hoped for. Venesection, the treatment spoken of, is as a rule now the last resort in desperate cases of venous obstruction due to diseases of the chest, and this perhaps is its true position and value in most instances, affording, when sucessful, a mechanical relief when all other means are unavailing, and the mere obstruction is certain to prove fatal. Thus it ranks with such methods of treatment as paracentesis, abdominis and thoracis, puncture of dropsical legs, etc., all of which are common-sense methods of saving the patient's life, temporarily or persevering the integrity of the part affected, when they are threatened by distension. These operations are to be avoided if possible; it is no doubt better in every way to be able to administer stimulants and other remedies, and so keep up the failing distended heart in cases of venous congestion in chest diseases, and by diuretics, and perhaps purgatives, in ascites, and œdema of the extremities to remove the offending fluid, and by some of the rather unsatisfactory means at our command to relieve the pleura of serum and the lung of the consequent pressure, than to have to confess that only mechanical help can be given. But if we allow dislike to these operations to weigh too much with us, we are liable to trust too long to the medicinal treatment so often unsuccessful, and, by delaying the mechanical means of giving relief till the condition of the patient or the part is hopelessly damaged, to render useless a plan of treatment which might have succeeded if applied earlier. The great difficulty is to know how far we may depend upon medicinal means, and when we can look to them no longer, this knowledge of course comes only from a long and intelligently-used experience; one more difficulty is the dislike which so many patients have to surgical treatment of this sort, unless there be urgent need for it.

We students have of course had little experience, but this is a failing which time will surely remedy (as a great statesman once said when taunted with his youthfulness,) if only we use it aright and avoid that evil result of an unobservant and unthinking experience, a routine manner of considering disease and its treatment. The histories of the two cases are shortly as follows. The first, a man aged 57, admitted last month with dropsy of legs, abdomen and scrotum. He had been exposed to wet and damp a good deal in his work, some time ago was under Dr. Taylor for dropsy, had also been under treatment for rheumatism. He had suffered from cough about 4 weeks before admission. On admission he was found to have dulness at the left base of the lung, bronchial breathing and râles, hypertrophy of heart, but no bruit, anasarca, and abundance of albumen in the urine, sp. gr. 1020. Cough became better for a time and expectoration. The quantity of urine at first became smaller and contained abundance of albumen and casts. March 14th, there was a pleuritic rub on the right side. March 19th, cough worse, dyspnœa, T. 104·3. March 21st, flushed, much dyspnœa, T. 102. March 22nd, much worse, with cough, dyspnœa and pain in præcordial region, bled to 8 ozs; afforded but little relief by this. Died, March 21st.

The post-mortem examination showed old and recent pleurisy on right side and much sero-purulent fluid in left-chest. *Lungs*, left lower lobe in a state of grey hepatization, upper compressed and airless, right lung healthy, *Pericardium* contained $1\frac{1}{2}$ oz fluid and showed some recent lymph. *Weight of heart*, $16\frac{1}{2}$ ozs, nothing wrong with the valves. *Abdomen* contained fluid. *Kidneys*, 11oz, surface granular, cortical portion wasted, some fatty change also, gouty deposit in toes. This then is a case of renal disease with albuminuria and general dropsy, pleurisy and slight pericarditis in whom pneumonia of one lung came on and caused so much dyspnœa, that venesection was considered necessary; though this gave very little relief it must not be thought to have been unjustifiable, it was the only thing remaining and gave the chance of temporary benefit at least; if it does nothing more than this it is right; but I believe that in these conditions if temporary relief is given a greater opportunity is given for nature to overcome the disease permanently. No doubt such a man would not have lived very long afterwards but that is not our business at the time, it is for us to obviate the present tendency to death, and, if we are successful, then to think of the ultimate result.

The other case is that of a woman aged 63, admitted

on March 21, 1877. She had been in the Hospital a year before for much the same complaint, and had been relieved. The present attack came on only a short time before admission with cough and dyspnœa and dropsy. She was admitted in a very cyanotic state, suffering from much dyspnœa, considerable anasarca, irregular action of heart, no bruit heard. There was evidence of bronchitis, but the chest was not examined thoroughly on account of her great dyspnœa. On March 22nd she was ordered to be cupped, but hardly any blood could be drawn on account of the stagnant state of the circulation; the next morning she was bled from the arm to 10ozs. and for a time was relieved in her breathing and her pulse became stronger. In the evening I found her worse again and got the ex-dresser to bleed her again this time the blood had to be taken from the external jugular vein on account of the swollen state of the arms; 14ozs. were drawn and she appeared decidedly relieved, more so than in the morning. However she only lived until the following morning and then died rather suddenly, probably from syncope; her breathing was not much worse shortly before death.

The post mortem examination showed fluid and recent lymph in left pleura, some emphysema and pus in the tubes of the left lung, right lung emphysematous; recent pericarditis. *Heart*, 15 ozs. mitral valve healthy aortic showed one vegetation about the size of a pea. *Abdomen* contained fluid. *Liver* well marked, nutmeg appearance. *Kidneys*, surface granular, capsule adherent, cortex wasted, weight 9 oz. No gouty deposit in toes. In this case the relief by venesection was more marked, and certainly prolonged life for at least 24 hours: this in itself is a great deal; but further, the patient was again put into a position in which nature might overcome the disease. Had not the condition been so much advanced when the operation was performed one might fairly have hoped that such would have been the case.

W. A. KIDD, M.B.

HYDROPHOBIA, TREATED WITH CURARE, GLYCOSURIA. DEATH.

William C., 34 years of age, carman. Bitten by a large brown retriever on the left wrist, six weeks ago. The dog was destroyed the same night, and he came to Guy's; the wound was about an inch and a half long. No caustic was applied. He attended a few days until the wound healed. Went about his work, but was rather depressed in his mind. On Wednesday last, this being about five weeks after the bite, he became very melancholy, and complained of pain shooting from the scar of the wound, up the arm and down to the end of the thumb and fore-finger. On Thursday was still more depressed, and on Friday begun to have difficulty in swallowing solids and liquids, especially the latter. On Saturday, he began to get excited, talking much, but not actually violent, until early on Sunday morning, when he had to be held down during his paroxysms. Got worse and was brought to Guy's (Sunday, March 11th).

He is a muscular man, light complexioned, medium height. Speaks rationally, except that he has a delusion that all his symptoms are due to poisoned medicine. Has paroxysms every few minutes. Has an anxious look. Dr. Taylor ordered Curare to be injected subcutaneously, beginning with $\frac{1}{10}$ grain at 12 noon; $\frac{1}{4}$ at 12·30; $\frac{1}{3}$ at 1·30; $\frac{1}{2}$ at 3 p.m. $\frac{1}{2}$ at 5 p.m. He seemed to get much quieter and slept for some time. About 7 p.m. became restless and suspicious, and very desirous of leaving the hospital. At 10 p.m. morphia was injected subcutaneously ($\frac{2}{3}$ gr.). Gets out of bed, and charges us with attempting to smother him. He passed some urine later on, the trickling of the water bringing on a convulsion. Became more and more violent, yelling loudly. Strapped down at 2 a.m. Struggles now incessantly. Talks without ceasing. Implores us to kill him. Has an acutely maniacal expression. Being strapped down seems to irritate him, and his struggles never stop. Every muscle seems to be in action, almost exactly like a bad case of Chorea. Stringy white mucus collects in his mouth, which he spits about.

About 7 a.m. he began to have periods of exhaustion, lying quiet, and almost ceasing to breathe for a few seconds, then starting suddenly and struggling as before. These intervals became more and more frequent, the struggles became less violent and less frequent, and he died quietly at 9·55, with a horrible contortion of his face. He had not defæcated in bed, nor were there any emissions. The bed was wet with urine. The urine he passed at 10·30 last night, had a specific gravity of 1030, loaded with lithates and a quantity of sugar. No albumen. Post-mortem showed general congestion of viscera, and spinal cord, and its membranes.

In the above case Curare had a fair trial; and though there was a period of improvement, it was only transitory. The symptoms of curare poisoning are not known in man; but it produces diabetes in dogs. The urine passed by this patient, after the injection of the drug, was diabetic.

A case has been recorded in the *British Medical Journal* for March 17th, where no specific treatment was adopted, and still the urine contained sugar.

Sugar, has also been found in the urine in cases of Tetanus, and other cases of violent muscular effort. Of course it is impossible to say whether the sugar in this case was due to the muscular exertion or to the action of Curare.

DISLOCATION OF THIGH IN A CHILD.

Rosa C., æt. $5\frac{1}{2}$ years, was brought to the Hospital

in consequence of an injury to the right hip caused by a fall in the street while running to school. When standing upon the left leg the right limb was kept semiflexed, and much adducted, the right knee resting upon the left thigh considerably above the knee of that side; there was also inward rotation. Nelaton's line showed elevation of the great trochanter to nearly 1 inch above its normal position. Bryant's line did not give such well marked evidence of displacement. The head of the bone could be distinctly felt lower down, and more posteriorly than is usual in dislocation upon the dorsum; this fact, coupled with the position of the adducted knee, induced Mr. Forster to diagnose "Dislocation of the femur below the tendon into the Sciatic notch." Reduction was readily effected by Mr. Horrocks under chloroform by "manipulation," viz., Flexion adduction, circumduction and extension. The bone re-entered its socket with an audible snap.

The points most worthy of notice in this case appear to be the age of the patient; dislocation in so young a subject, being we thought not unprecedented; it would suggest itself that incipient hip-joint disease might possibly be indicated. Another unusual circumstance was the fact that the head of the bone could be readily felt in its new position, a condition which is described as being less usual in dislocations in the Sciatic notch or its neighbourhood, than in dislocations on the dorsum, *i.e.*, above the tendon of the Obturator Internus. The position of the foot of the affected limb was also unusual, the knee was flexed, hence the foot did not rest upon the toes of the opposite foot. After reduction the legs were bandaged together and the child kept at rest in bed. She will probably leave the Hospital in a few days.

G. A. WRIGHT.

Mental Diseases.

BY DR. G. H. SAVAGE, OF BETHLEM HOSPITAL.

NOTES ON LECTURE VIII.

OTHER STATES OF MENTAL WEAKNESS.

Besides the state of acute primary dementia, we have to consider states of mental weakness that are consecutive to acute forms of mental trouble. By far the greater number of patients attacked by mental disease, sooner or later pass into weak-mindedness.

This state is very imperfectly understood by doctors not having asylum experience, and is completely misunderstood by most lawyers. A patient who has been dangerous, incoherent and voilent, becomes quiet, coherent and well behaved and yet be unsound and certain never to regain his mental health. Some, one false set of ideas or of subjective sensations, remain and fix as it were the mental tone. In some cases the rapidity with which an acute attack passes off leaving permanent weak-mindedness is astonishing. Some causes seem to lead more certainly to weak-mindedness, such as the more coarse injuries to the brain, produced by direct injury, sunstroke, sudden shock and the like. Mental disease with epilepsy too generally ends in weak-mindedness.

Under "weak-mindedness" we class various forms of disease, or I should prefer to say various expressions of disease, we may have simple dementia more or less complete, which resembles in physical symptoms, the form of disease described in my last lecture, chronic mania or melancholia, and varieties without end of monomanias or delusional insanities.

In all the above there are some common characteristics, and the most remarkable, and the one most to be relied on is the fact that the patients are in one or more particulars unlike their former healthy selves.

A careful house-wife gives up all her household duties to attend Church meeting. A promising student gives up study and neglects his dress to preach the gospel to the poor. A liberal man becomes a collector of rubbish. A quiet religious man takes to drink and adultery. My experience is, that it is rare for mature people to change completely their habits, unless their body is changed too. In all the forms of weak-mindedness there is more or less intellectual loss, this is not always easily proved, and it must be remembered that the chronic insane have times in which they are more sane than at others. You will find the easiest test of a man's intellect in his opinion of other patients—if he be in an asylum. We have had one or two doctors in Bethlem lately who could have judged of the insanity of their fellows years ago, but now see nothing unreasonable in the maddest acts, these are chronic cases and will not recover. The intellect may suffer and yet the patient may know right from wrong, besides the reason, any or all of the other parts of the mind may be damaged. There is more or less sluggishness of thought, loss of memory and of mental association, with weakness of emotion or will, a great inability to accommodate oneself to the surrounding, thus these patients settle into their places in an asylum, and seem to friends and visitors as quite rational, but vary the surrounding and let them go home, and a break down results at once.

They often are unable to correct false impressions, and then arise delusions from a mistranslation of ordinary sensations. These delusions may result from an incoherence of thought or from hallucinations. Hallucination of hearing are common and very tractible as a rule. It is almost an impossibility to get at the reason of a patient thus affected, he will say "O yes I hear your voice but I hear another voice; that I believe is the voice of God and of course I follow that."

I shall best explain the varieties of weak-mindedness by giving brief histories of cases.

A. T. single, æt. 25. Mother insane. A lawyer. He began his profession when young and was careful and industrious, he then became "fast," took to gambling, and other vices at the same time developed inordinate vanity, he next changed his religion and about the same time wrote incoherent, and excited letters about religion. He became dull and desponding and refused food, for a time he was again excited, but there was feebleness and indecision in his acts. This increased till he became simply a machine. He smiled if roused and ate if fed. He slept almost all his time away. He was no longer dull or excited. Nothing was left but animal functions.

In the above we see well marked the change of character already noticed as occurring with insanity. We see many "converts," who "vert" when insane.

The next case is one of melancholy passing into dementia.

Edith B., Single, æt. 23, Governess. Has had neuralgia and has been hysterical. Three months before admission became restless and depressed, unable to rest and sleep, fancied she was "lost," and that great poverty was at hand. She was suicidal. Had amenorrhœa for some months and general depression of vital powers. Circulation sluggish, skin cold, bowels confined, appetite bad. After admission she slowly and steadily increased in weight, but did not alter mentally in the least. She would ask for work but when given to her she would not do any. She was emotional. She became less tidy

and then dirty. She would sit for hours unoccupied and uncomplaining. She became fatter and less melancholy, but willess and melancholy weak, and at the end of twelve months was discharged uncured.

Another similar case, a lawyer of middle age became dull, neglected his business, and at length was sent to Bethlem. His mother was insane. He gradually lost all power over his will, and would hesitate about the most trifling thing till forced to act. His case was instructive in showing how those who have lost the control of their wills, and yet who do certain familiar acts fancy they are guided or "influenced" by others. He slowly became more and more weak-minded, and was discharged uncured after two years treatment.

We shall only glance at the dementia of general paralysis, as that will more naturally require discussion with general paralysis. In most cases of this affection sooner or later a stage is reached, in which all the mental functions are weakened. The patient who has talked of his millions, repeats the same tale over and over again, forgets from time to time whether he has already seen you.

He will talk of millions on one hand, and yet truly tell you he received thirty shillings a week, and has £50 at the savings bank. He is often emotional and impulsive, but as a rule is childlike in being easily led.

The rate of mind decay varies, but is almost always most rapid and most marked in those having early epileptyism seizures. In fact we often first note the fact of loss of memory after the first fit.

Next we note cases of Chronic Mania.

A single man of 45 who was anxious to get into holy orders. He had spent many years as an unpaid district visitor. His family was of a highly nervous nature, without warning he became noisy, violent and utterly unlike himself. Drank to excess and became amorous and oppressive. On admission to the hospital he was a most typical case of mania. His noisy, monkey like form, his quick perception and restlessness, with utter disregard of the convertionalities made him noteworthy. We expected a cure at first, but time went on and he did not improve. At first he wrote tracts that were sensible at least and carefully written, but later he became untidy in dress and careless in writing. He also became uninfluenced by reason, his emotional side weakened, as shown by his reply when he heard his favorite brother was dead "all right I'll write his funeral sermon." After three years treatment he was discharged uncured.

Many other cases of interest might be named, such as that of the Oxford man who had several attacks always associated with religious version, who used to spend hours and days in making patchwork symbolical robes, and in writing masses by the hundredweight, or the artist who signed himself "Coward Jesus," or the greyhound trainer whose medley of Derby winners and greyhounds was very odd.

Sufficit that with these chronic maniacal states there is weak-mindedness.

Chronic melancholia is a parallel condition, a patient having suffered from melancholia may become demented, or a chronic case if not cured, and you may have all the varieties of melancholia exhibited.

Thus—Miss N. a woman of good ability, was distressed by some business and social worries and became wretched and finally melancholy, fearing that great evils and ruin must result from her conduct, that she was damned and must commit suicide, for a time she improved and then passed again into her wretched state.

She passed the whole day wringing her hands and saying "I don't know what to do," this continued for over two years. She seemed absorbed in her woe, and nothing else caused her concern. She will continue thus till worn out. In other cases the complete absorbtion of all the mental powers by the melancholy state is less distinct because less demonstrative.

Other cases never get free from a dread of ill, that so exhausts their nervous centres that they become demented, others get in a sense weak-minded from a fear of committing suicide, and in most asylums will be found cases secluded much to their own satisfaction as they cannot control themselves. It is a question whether chronic drinkers had not better be treated as weak-minded also.

Weak-mindedness may accompany ordinary hallucinations, that are neither melancholy nor maniacal in character, but may cause great danger.

A tall big man, æt. 30, now in Bethlem, hears voices *accusing him and calling him names. At other times making* beastly suggestions to him. He is fully occupied with these subjective sensations, and his other faculties are failing.

Many other patients have fixed delusions often associated with ideas of poison and violence, and gradually become weak-minded.

I can only hint at the chief groups of the great class "weak-mindedness."

Every case if it can be traced is a page of most instructive nerve pathology, and as yet more can be learnt from the history than from the tissues.

NOTICES OF BOOKS.

"Handy" Medical Visiting List. By Dr. Alfred Sheen. (William Lewis, Publisher, Cardiff.)—This little book certainly deserves the title of "handy," for it is made of a size to fit easily into an ordinary pocket-book. The internal arrangement and the system of marks for registering appointments, &c., are both remarkably simple but quite effective; and hence, as a practical diary, this little volume will doubtless prove very useful to the busy practitioner. In addition it includes some capital therapeutical tables, a graphic method for calculating probable date of labour, and a useful table containing the proportion of alcohol in all ordinary wines and malt liquors; thus it forms a veritable *multum in parvo*, moderate in bulk and price. Neat little temperature charts, 6 inches by 3 inches, form a useful *addendum*, and can be obtained from the same publisher.

ON DUTY FOR APRIL.

House-Physicians:—F. Coley, M.R.C.S., W. A. Kidd, M.B.
Junior House-Physician:—T. L. Porter, M.B.
House-Surgeon:—H. F. Lancaster, M.R.C.S., L.R.C.P.
Junior House-Surgeon:—M. Lubbock, M.R.C.S., L.R.C.P.
Senior in Charity:—A. Finch, M.R.C.S.
Junior in Charity:—W. C. James, M.B.

DRESSERS FOR THE WEEK.

March 28th, Mr. C. K. Shaw (Mr. Bryant).
April 4th, Mr. E. C. Green (Mr. Durham).
" 11th, Mr. Lowdell (Mr. Howse).
" 18th, Mr. Uhthoff (Mr. Forster).
" 25th, Mr. G. Mackern (Mr. Bryant).

We have received the sum of 10/6 from R. H. Hughes, and the following subscriptions of 5/6 from

George Eastes	F. T. Paul
A. Gillingham	Dr. Pickerstock
Sir W. Gull, Bart. M.D.	Dr. Locke
N. H. B. Hall	H. N. Smith
E. Lynes	Dr. H. Wood.

And the following subscriptions of 5|-

H. G. Ashwell	C. G. W. Lowdell

GUY'S HOSPITAL GAZETTE, *APRIL*, 1877.

ON reviewing the work done at the Physical Society during the session just ended, we are justified in regarding it as successful. Dr. TAYLOR, in his speech at the closing debate, said that the attendance of members all through had been above the average, one night in particular the number present exceeded the highest number of which he could find record in in any former meeting of the Society; it was noticed also that the 1st and 2nd years were better represented by numbers than is usually the case, and this may partly be accounted for by the occurrence of several physiological subjects among the papers read during the last session, but we also trust that it shows increased general interest among the students; as far then as regards attendance it may be put down as good. Turning over to the character of the debates generally, and of the remarks made, we may say that the discussions on the whole have been more lively, there were fewer of those dread intervals of silence, which often seem to paralyse intending speakers, and though the speakers cannot be said to have carried their remarks to an unseemly length, in any one instance even, yet what they said was usually to the point, and if richness of material was the exception, there were always brave men found ready to go to the front at any rate; particularising the discussions we should specially mention those on "Hysteria," "Sclerosis," "Tobacco," and "Epilepsy," as being some of the best we have heard for some years.

Among the speakers two or three as usual stand out prominent, and we expect great things from one or two of the junior men next winter session. It is not easy, nor is it in fact necessary, to say much about the papers read before the Society, as the decisions of the Presidents seem to have given general satisfaction. There seems to be a common idea about, that originality is a *sine quâ non* in a paper; if so, then we are afraid there would be a scarcity of papers, not only at our Society, but also in many other and more pretentious assemblages; of course originality is very desirable, but it should never be obtained at the expense of common sense, and of the knowledge of ascertained facts, originality in the method of treating a well known subject is very desirable, care should be taken however that the "individual" be not lost in its new covering. A good many original ideas were scattered through the papers generally, a few destined to survive, the rest were doubtles found very useful by the debaters as points of attack, and had but a little existence; the attempt to connect Acute Rheumatism with the Lymphatic system, and especially characterising it as an inflammation of the Endothelium in the first instance, was ingenious and original as far as it went, but the debate proved that the non infection of certain endothelial surfaces was not sufficiently explained. There is a great deal in the systematic arrangement of the material of a paper, and two of the of the prize papers, namely those on "The Sympathetic System" and "On Pyrexia, and method of reducing it," were good examples. It is remarkable to see what a prominent position Physiology held in the programme, no less than three papers were purely physiological and scientific, while Surgery and Practical Medicine were almost absent; these facts brought some weighty remarks from Dr. WILKS at the last meeting, he deplored the tendency to write on theoretical and elementary subjects, and suggested for the future some more practical subjects such as "Obstruction of the intestine," "Granular Kidney," &c., &c.; on the whole, however, the subjects were treated in as practical a manner as possible, and we ought to remember the very great difficulty there is in drawing the correct deduction from a number of elementary facts. Encouraged, then, by the success of last session, we will start next winter with the hope that "The Physical," the oldest institution at Guy's, will continue to hold the important place it now does amongst us.

Physical Society.

Meeting, March 3rd, 1877.

Mr. LEE in the Chair.

Mr. DEANE read a paper on "Some Remarks on Practical Physiology," stating the importance of learning Physiology as much as possible by experi-

ment, and not simply by reference to books which give but a vague idea of the subject.

To one commencing the study by means of a few simple experiments, many fundamental facts may be learnt which remain implanted in the memory, which if simply read are too soon forgotten

The results of many simple experiments and observations were then made to help to prove the truth of his statements, and, on concluding it, remarked that they were mentioned for the sake of showing that they could easily be done, and not how to perform them.

Mr. Roper questioned if we had time to learn physiology in the way advocated by Mr. Deane; there was so much in medicine and surgery to be learnt that a man had not time to do this: let him learn his physiology out of Kirkes and he would do well enough. He doubted Mr. Deane's statement as to a frog having no kidney, as Dr. Beale speaks of the tubes of a frog's kidney as being lined by caliated epithelium. He approved of the study of the microscope as being so useful afterwards in practice.

Mr. Shaw said he was not a great physiologist himself, but approved on the whole of Mr. Deane's method of studying physiology, specially because it cultivated dexterity of touch, so useful in practice.

Mr. Wainewright thought it was not easy to debate on the paper, so much of it was composed of well-known facts; he maintained the utility of practical physiology, and recommended the study of animal physiology before entering a Hospital. He instanced the pulsation of the vena cava inferior, mentioned by Mr. Deane, as one of the tangible advantages obtained from such study, this helping one to understand better how the venous circulation is carried on.

Mr. Uthoff agreed with Mr. Coley, he thought that it depended upon what a man liked which course he would take in learning physiology, simple experiments like those of Mr. Deane's might be learnt without performing them oneself. It was the more difficult points in physiology which were made so much clearer in this way.

Meeting, March 17th.

Dr. Wilks, F.R.S., in the Chair.

Mr. H. Davy read a paper on "The Pathology of Acute Rheumatism in Relation to Treatment."

Having expressed his regret that Mr. Masters was prevented from reading his paper, he said, "It is the curse of medicine that Doctors always think that they must interfere with the course of a disease; and, with an obstinacy which is the offspring of ignorance, continue to laud remedies as specifics, even when common sense should tell them they are only using slow poisons. Of no disease is this more true than of Acute Rheumatism. Unfortunate patients having been bled to death, or mercurialized out of this world into the next, with a dogged calmness which speaks well, only for the firmness of nerve of the older race of Practitioners." He then sketched a case of the disease with its morbid anatomy, and discussed the features said to support the Lactic acid theory. "Much stress," he said, "had been laid on the fact that the urine highly coloured and *acid* during course of the fever became *alkaline* at defervescence, but he (Mr. Davy), could not attach much importance to this, since Dr. Roberts of Manchester, had proved that the urine is normally alkaline after every meal, while Mr. Murphy, of the London Fever Hospital, found that the acid urine of Scarlatina or Enterica invariably becomes alkaline, as convalescence was established in all cases in which it was carefully and frequently tested."

"Bristowe and others consider Acute Rheumatism to be a local inflammation affecting connective tissue, which tissue happening to be largely distributed throughout the system, causes the disease to simulate a constitutional disorder." Mr. Davy, however, would consider "Acute Rheumatism to be due to an inflammation of the Endothelium in the Lymphatic system of connective tissue, having perhaps many exciting causes but capable of being set up by exposure to cold." He first called attention to Dr. Kleins researches. Dr. Klein divides each Tendor &c., of Connective Tissue into a number of what he terms microscopic bundles (which are however visible to the naked eye), and by staining with Nitrate of Silver, he proves that each of these is surrounded by a tube of Endothelium, or as we may term it, runs in the middle of a Lymphatic. How great then is the amount of this tissue in the body distributed as in connective tissue throughont every organ, how immense is the amount of Endothelial Lymphatic Tissue collected around joints with their capsular ligaments, muscular tendons and synovial cavities. He then called attention to the proneness of this tissue to become inflamed, as illustrated by the fact that the Pleura, &c., which are lined with it, more readily become inflamed after exposure to the cold, &c. This inflammation too would cause the clinical features of the disease. It would cause the Hyperinotic state of the blood, which according to Virchow is due to an increased supply of Lymphatic fluid into the blood, the fibrine being a local production due to nutritive changes within cells. It too would cause a blocking up of a greater or less number of lymph spaces, the endothelial cells becoming multiplied or hypertrophied, and this would produce agonizing pain, hyperæmia, and those nutritive changes which p.m. reveals. Finally he supported this theory by facts seen in pyæmia, Gonorrhœal Rheumatism and the frequency with which Scarlatina is complicated with Rheumatism and Pyæmia. Remarking on treatment he said, "do not let us look upon our patients as if they were so many test tubes of an acid solution which it is our first and only duty to neutralize," contending in spite of some statistics to the contrary that the alkaline treatment was a failure. "Much he thought was to be hoped for from a judicious use of Salicin, which being nearly allied to Quinine he thought influenced cell life, as research had proved the latter to do. At any rate much can be done to relieve the patient by Hygienic measures and local applications. Should fomentations (especially strongly sedative fomentations), fail to relieve pain he strongly recommended the application of blisters."

Mr. LANE in rising to open the debate, regretted the unavoidable absence of Mr. DEANE.

Mr. LANE had been asked by Mr. DEANE to open the debate with special instructions to criticise the paper. Why he was to criticise it, he was not told, and as he felt unable to do so, he wished Mr. DEANE had been able to be present. He then spoke of the connection between Chorea and Acute Rheumatism. With regard to blisters he thought the pain they caused was even worse than that of the rheumatism.

Mr. HORROCKS prefered to consider Acute Rheumatism to be a constitutional disease. Hyperinosis was to be observed in Pneumonia and several other conditions, and so he did not consider it much helped Mr. DAVY's theory.

Mr. SHADWELL observed that some time ago he had read a paper before the Society on the treatment of acute rheumatism, and he was glad to find that Mr. DAVY had arrived at the same conclusion as himself with regard to the Alkaline Treatment, although by another road. He then quoted statistics as to the duration of the disease under various systems of treatment, the result of which went to show that the disease lasted the shortest time when treated with quinine.

Mr. RUSSELL would not venture to discuss the Pathology of the disease, but he could not agree with Mr. DAVY's sweeping denunciation of treatment. He thought much might be done, and recommended soothing applications and the Alkaline treatment.

Mr. MACKERN had lately been reading the researches of Tillman on the Lymphatic System and he could not help thinking that an inflammation of their Endothelium would account for all the symptoms of Acute Rheumatism, as far as regards joints. At the same time he believed in a humoral pathology for the disease, and inclined to the theory that the inflammation was set up by the circulation of some poisonous material in the system.

Mr. COLEY spoke on the treatment of Acute Rheumatism by Salicylic Acid. He believed this drug to be in all cases potent for good or for evil, generally it acted most advantageously after a few doses, but occasionally it seemed to do no good but to act quite deleteriously, producing headache, deafness or delirium. He quoted many cases in support of his remarks.

After the discussion, Dr. Taylor read the report of the Presidents, and the prizes were distributed as follows:—

£10 to Mr. R. S. WAINEWRIGHT, for his paper on "The Sympathetic Nervous System."

£5 to Mr. HORROCKS, for his paper on "Hysteria."

£5 to Mr. C. KNOX SHAW, for his paper on "Pyrexia and methods of reducing it."

There was no essay sent in on "Granular Kidney."

The debating prize, £5, was awarded to Mr. Uhthoff.

The following new presidents were declared for the next session. Messrs. Wainewright, Uhthoff, Shaw, Horrocks, Birdwood, Wright and Hartley.

After the usual vote of thanks, the business of the meeting terminated, and the Society concluded a very successful session.

Football.

THE INTER-HOSPITAL CHALLENGE CUP.

Guy's *v.* St. Thomas's.

The final tie for the possession of the Challenge Cup was decided at the Oval on Thursday, Feb. 3th. Soon after three Leatham kicked off for St. Thomas's against the wind but the ball being well returned by Stokes, the first scrimmage was formed in the St. Thomas's ground. A short run by Maybury took the ball into the middle of the ground, but Stokes by a fine drop removed the play into the St. Thomas's twenty-five. Gray then obtained the ball and nearly dropped a goal for Guy's. Jackson now made his mark near the touch line, and Pearson made a fine shot at goal, compelling St. Thomas's to touch down. Soon afterwards Gray made another good drop at goal, forcing St. Thomas's to touch down for the second time. After a number of scrimmages had taken place, in which St. Thomas's had the advantage, the ball came to Stokes who made a good drop, and forced St. Thomas's to touch down. A good run by Leatham relieved St. Thomas's for a time, but Stokes by a long drop, reduced St. Thomas's again to the extremity of a touch down. After this some good forward play by St. Thomas's took the ball into Guy's territory, and Jeffreys by a feint made Guy's touch down for the only time during the match. Ends were then changed. Gray kicked off for Guy's, but shortly afterwards had to retire having dislocated his shoulder. For some time St. Thomas's had the best of the play, and Leatham had two tries from fair catches, but both were unsuccessful. The ball then came out of the scrimmage to Jackson, and he passed it to Stokes, who by means of a run and a long drop forced St. Thomas's to touch down. Soon after "no side" was called, so that Guy's were left the victors by six touch downs to one. Besides those already mentioned, Penny, Jackson, Keer and Roberts played well for Guy's; and for St. Thomas's, Maybury, Lunn and White.

Guy's.—W. G. Gray (Capt.) and A. H. Jackson (half-backs), A. W. Pearson and E. Penny (backs), L. Stokes (three-quarter-backs), J. C. Keer, J. Boswell, J. A. Fraser, H. Liddell, R. Gordon, J. Rees, Q. R. Veitch, D. D. Roberts, F. Wilkinson, C. Pink (forwards).

St. Thomas's.—H. B. Leatham (capt.), H. P. Butler (backs), E. F. White. A. C. Wallace (three-quarter backs), J. P. Jeffreys and L. Maybury (half backs), S. A. Crick, F. N. Heygate, L. Houghton, T. R. Lunn, W. W. Groome, H. Wood, H. Praugley, M. Collier, W. F. Price (forwards).

RESULTS OF THE PAST SEASON.

Matches played, 18; Won, 10; Lost, 5; Drawn, 3. Goals won, 23; Lost, 11; Tries won, 15; Lost, 6.

Oct. 14th, at Stamford Brook.—*v.* Harlequins. Lost by two goals.

Oct. 21st, at Blackheath.—*v.* Blackheath. Drawn in favour of two touch-downs to one.

Nov. 11th, at Clapton.—*v.* Oakfield. Won by a try.

Nov. 18th, at Battersea.—*v.* Flamingoes. Won by two goals and two tries to nothing.

Nov. 21st, at Blackheath.—*v.* St. Bartholomews Hospital. Won by three goals, and three tries to nothing.

Nov. 25th, at Blackheath.—*v.* Harlequins. Drawn.

Dec. 13th, at Greenwich.—*v.* Naval College. Won by six goals, and three tries to nothing.

Dec. 16th, at Blackheath.—*v.* Beckenham. Won by two goals, and one try to nothing.

Jan. 13th, at Blackheath.—*v.* Oakfield. Drawn in favour, three touch-downs to nothing.

Jan. 20th, at Blackheath.—*v.* Clevedon. Lost by two goals to nothing.

Jan. 24th, at Battersea.—*v.* St. Bartholomew's Hospital. Won by one goal to one try.

Jan. 31th, at Blackheath.—*v.* Hill's team. Won by two goals and one try to nothing.

Feb. 3rd, at Beckenham.—*v.* Beckenham. Won by six goals and two tries to nothing.

Feb. 10th, at Richmond.—*v.* Richmond. Lost by one goal *and two tries to one goal.*

Feb. 15th, at the Oval.—*v.* St. George's Hospital. Won by two goals and two tries to nothing.

Feb. 17th, at Putney.—*v.* Gipsies. Lost by two goals and one try to nothing.

March 8th, at the Oval.—*v.* St. Thomas's Hospital. Won by six touch-downs to one.

March 17th, at Blackheath.—*v.* Blackheath. Lost by four goals and three tries to nothing.

Correspondence.

To the Editor.

Sir,

I have read in the *Gazette* for March a letter from "One who has not been refused his appointments," which touches, in my opinion, on a subject of no small importance.

As the management of *our* journal is in such good hands, I have no fear of anything arising to remind one of the "adjutators" or "agitators" in the army of the Commonwealth, for I am quite sure that the Presidents of the Physical Society would put down anything of the sort with as strong a hand as old Cromwell did in his time. Yet, as we juniors do not live under military discipline in connection with our *alma mater*, I think a discussion of the subject raised by your correspondent, if not carried on in a cantankerous spirit, would lead to no harm and perhaps some good, if only it satisfied your correspondent and those who may think like him that the present system of dresserships could hardly be improved upon.

It is quite true that but a small proportion of Guy's men who qualify and go into practice have held the dressership; but your correspondent is mistaken if he supposes that the appointment is conferred mainly on those who have distinguished themselves in any remarkable way.

My experience of Guy's men would lead me to divide them into the two great classes of those who appreciate their appointments and endeavour to work them well, and those who employ their time otherwise, as may seem well to them, doing their appointment-work in a perfunctory or slovenly way. To the former I should give the generic name "good men;" as for the rest—well, it is not to the point to take any further notice of them.

Now, since I have been at Guy's, I have known of several "good men" who have gone into practice without holding the dressership while they were with us. For this there are more reasons than one. They may never have tried for it, having, perhaps, sufficient practical experience picked up in other ways, perhaps more than ordinary self-reliance or self-assurance. They may have tried once, but, having to compete with a senior or a better man, they failed then, and, thereupon abandoned the idea and fell back on the kind of considerations I have just pointed out.

These conditions must much reduce the number of men supposed to be hardly dealt with, while, at the same time, they diminish the obstacles in the way of a good man who has set his mind on getting the dressership. In fact, I believe, that such a man always will get the appointment sooner or later. Still, this does not answer the question *all round*, and, it may be, some of the men I have referred to would have done better had they stopped to hold the dressership at Guy's.

I cannot see the practicability of the arrangement which your correspondent suggests. The institution of "dresser for the week" is an excellent institution, and I do not see how the very important casualty department of our hospital could be carried on without it. There must be some responsible man always on the spot ready for any case that may suddenly be brought in, and it would never do to trust to an assistant-surgeon's dresser, who, as likely as not, would not be on the spot, and who has no special responsibility put upon him. The house-surgeons always have their hands full enough and could not be called upon. The only feasible arrangement that I can think of, which would make the special advantages of the dressership more extended, would be a shortening of the term of office. If the term were three months instead of six, then forty-eight men instead of twenty-four would be appointed in the year. Each man would have one "take-in" during his term of office. With his surgery dressership with its practice in minor casualities, including fractures of the upper extremity—which point, by the way, your correspondent appears entirely to have lost sight of,—his practice as assistant-surgeon's dresser, and his three months of senior dressership, he would have had, I think, a very fair *run* of practical training, if he made the most of his opportunities of seeing, hearing, and feeling.

Supposing this *curriculum* sufficient—and I think it *should* be—to turn out a good surgeon, then, on an average, Guy's would send out, as so many centres, twice the number of well trained surgeons that she has been wont to do. But there are many important arguments against this plan. It might be said that, as men go, the practice was not enough to make them thorough. I really think that a man's second three months in the dressership teaches him more than his first three months. He may want the first three to take the conceit out of him and to correct the premise in other ways. With a three months dressership he would not in every case see his cases out, those, that is, belonging to his "take-in;" while with the six months appointment he would always see one set out.

If it were shown that the short dressership would, on the whole, turn out a set of men *insufficiently* trained, then, I think, it would be most undesirable to shorten the appointment under the pretext of making surgical knowledge more diffused. With the present system Guy's sends out, at any rate, a few men year-by-year equal to the burden of public service; with insufficient training the few would be still fewer. I do not mean to say that the number of Guy's men equal to their duties *is* few, but that *insufficient* training would make them fewer or less great.

I have treated this subject purely from the view-point of public service. I hold that no other view is worthy. Neither have I answered it definitely in one or the other way.

Fortunately the judgment of it does not rest on my shoulders, but I have confidence in those on whom it does rest.

I beg to remain,

Yours truly,

J. M. HOBSON.

NOTES OF THE MONTH.

The Elimination of Urea in Diseases of the Liver.—M. Bronardel, in a paper on this subject, shewed how pathology bore out the prevalent idea among physiologists that urea is formed by and in the liver. In severe jaundice, and in jaundice caused by the toxic effect of phosphorus, the urea disappears or diminishes in amount, while it does not diminish in simple jaundice. In suppurative hepatitis the urea is augmented at first, but diminishes when the abscess has destroyed a large portion of the organ; this is also the case in cancer and cysts of the liver. Urea is diminished in cases of biliary calculi leading to obstruction of the ductus choledicus, in cardiac liver, and in fatty degeneration of the liver. Urea is increased in congestion of the liver, and in diabetes it rises to a higher proportion in some cases than in any other disease. Hence, in disease of the liver, the quantity of urea secreted and eliminated by the kidneys, provided they are healthy, is under the influence of two conditions—(1) the integrity or alteration of the hepatic cells; (2) the greater or less activity of the hepatic circulation.—*Practitioner*, March, 1877.

Michael Harris' Prize for Anatomy and Physiology. The Prize this year has been awarded to Mr. H. E. B. Flanagon.

PHOSPHORUS IN PSORIASIS.—Dr. Broadbent, at the Clinical Society, mentioned a case of obstinate psoriasis which, after having resisted all treatment, was cured by phosphorus in a week. Sir W. Jenner remarked that cases of psoriasis are plentiful, and that phosphorus capsules are to be had in abundance, and that, therefore, there should be no difficulty in enquiring into the use of phosphorus in this oftentimes very troublesome disease.—*Lancet*. Dec. 16th, 1876.

An interesting article in the *Sanitary Record* of March 9th, termed "A Lenten Fast," shows how the great fast of Lent, which is the Saxon for Spring, was not only an observance of the Church, but "it was, and to a less extent is still, a sanitary arrangement of a wholesome character." At the time of the Church's supemacy, the usual dietary at Easter consisted of herbs, roots, dried fruits and nuts; after a time also milk and eggs were allowed by special "indulgences," and the Church profited largely by the sale of these permissions. To see how this change of diet operated beneficially, it is necessary to enquire into the dietary of the people during the long winter, and we are told that "the staple food of the people consisted of salted meat, grain, pulse, cheese, a small quantity of apples and onions, and here and there in a sheltered nook a few winter greens;" no wonder then that scorbutic disease was common, in fact scurvy was then nearly as prevalent on land as on water, and when Spring brought a growth of vegetables, they were eagerly devoured; the descent of such a custom is to be seen in certain remote parts of England, where it is still customary to gather the young shoots of many wild plants as soon as they appear.

The occurrence of a so called fast between the festivities of Christmas and Easter, must have been highly beneficial, and it is interesting to see how it resulted from the combination of natural causes.

Jumeaux, B., L.R.C.P. Ed., M.R.C.S.E., has been appointed Medical Officer of Health, for the Oystermouth Urban Sanitary District, *vice* Young, resigned.

Stamp, W. D., L.R.C.P. Ed., M.R.C.S.E., has been appointed Assistant Medical Officer to the Infirmary and Workhouse, St. Luke, Chelsea.

THE SYMPATHETIC NERVOUS SYSTEM.

Read before the Physical Society 6th January, 1877, by R. S. WAINEWRIGHT. (Prize Paper.)

The Sympathetic Nervous System or Sympatheticus Major has received its name from the opinion that it is the means through which are effected the several sympathies in morbid action which distant organs manifest; for the same reason the Pneumogastic has been called the Sympatheticus Minor.

The Great Sympathetic was called by Béclard "the ganglionic nervous system," by Bichat "the nervous system of organic life." Bichat also gave the name of "abdominal brain" to the solar plexus on account of the mass of nervous matter which it contains. It is in consequence of the existence of this great nervous centre, that a blow in the region in which it lies always inflicts a severe nervous shock, and not unfrequently causes death.

I propose to first say a few words on the Development, then the Minute and Comparative Anatomy of the Sympathetic, and will then pass on to a more extended though very limited review of its physiological functions, and lastly will briefly recount a few of the diseases which implicate this system of nerves. The general descriptive anatomy of the sympathetic nervous system is so well known to all present, that it is needless for me to offer any remarks upon it, except perhaps to observe that Dr. Carpenter, unlike many physiologists, includes, as part of the sympathetic nervous system, the ganglia on the posterior roots of the spinal nerves, the Gasserian ganglia, and even the ganglia near the roots of the Vagus and Glossopharyngeal nerves,

The Development of the Sympathetic has not yet been fully made out. Quain states that Remak has seen the sympathetic nerve fibres proceeding from the lateral plates in loops or arches connecting them with the spinal nerves; while the great sympathetic itself consisted at first of a chain of rounded masses representing the ganglia, connected together, but so closely set, that scarcely any intervening cord was at first perceptible.

Kölliker has described and figured the gangliated cord of the Sympathetic in the human fœtus of eight or ten lines long. The peripheral sympathetic nerves are also formed at a very early period, and are perceptible in a fœtus of three months. In the hinder part of the abdomen their origin is said to be intimately connected in some way with the formation of the suprarenal bodies.

Besides the development of the suprarenal capsules being connected with that of the sympathetic, it is also remarkable that they have a very numerous quantity of large nerves from the Solar and Renal plexuses.

Bergmann has suggested that they are parts of the sympathetic nervous system; while Kölliker states, that, upon anatomical grounds, he is inclined to consider the cortical and medullary portions as functionally distinct, the former belonging to the group of vascular or ductless glands, the latter appearing to be an apparatus appertaining to the nervous system.

In that remarkable complaint known as Addison's disease, some cases have been reported, where, besides the primary affection of the suprarenal bodies, the whole chain of the sympathetic ganglia have been found to be diseased right up to the upper part of the neck.

I will now give a brief account of the minute anatomy of the ganglia and fibres of this system of nerves.

The ganglion cells of the sympathetic are partly united into large groups, to form the so-called ganglia or nerve-knots, and are partly intercalated in the course of the nerve trunks, or are distributed in a scattered manner in the various organs. To use Stricker's own words "in the cerebro-spinal medullary system the principle of centralisation of the elements is represented, whilst in the sympathetic system it is rather decentralisation, which is the special feature."

Each ganglia is provided with an investing sheath of connective tissue, which gives off processes that penetrate between the several cells and form a kind of separate capsule to each. According to Fräentzel, this capsule of connective tissue is formed by an expansion of the neurilemma of the nerves, and is lined by a layer of pavement epithelium.

In a ganglion the cells are founed to exhibit extraordinary differences in size, they also differ in shape, being chiefly oval, round, pyriform, or fusiform.

The sympathetic nerve-cells have a sheath, a proper cell substance, a nucleus and a nucleolus.

Stricker believes that some apolar cells (cells without processes) exist in the sympathetic; the greater number however are multipolar. Peculiar cells have been noticed by Drs. Beale and Arnold in the sympathetic in the Frog, they are bell-shaped, and from the small end proceed two processes, one straight, the other spiral, the latter coiling round the former.

Ganglion cells of the sympathetic cannot be distinguished microscopically from ganglion-cells of the cerebro-spinal system.

The cords of the sympathetic consists of medullated and non-medullated fibres mixed with a greater or less amount of filamentous connective tissue, and inclosed in a common external fibro-areolar sheath.

The white fibres vary very much in thickness; the smaller ones, though having a well defined sharp outline, have not usually a distinct double contour like that seen in the larger medullated fibres.

The non-medullated or true sympathetic fibres are usually supposed to correspond with the axis-cylinder of other nerves; resembling the condition of things in the family of the Petromyzon, a lowly organised fish, where the non-medullated pale appearance of the fibre, presenting simply an axis-cylinder, persists throughout life. The axis-cylinder has been found, by optical means, to be made up of extremely delicate fibrillæ.

Frey, however, describes the gelatinous sympathetic fibres, as "flat bands, sometimes transparent. Their appearance being usually homogeneous, with at intervals an elongated, oval, or fusiform nucleus."

The Comparative Anatomy of the Sympathetic Nervous System, to which I now turn, presents many difficulties.

At first sight, for instance, the ganglia of the sympathetic arranged on either side of the vertebral column remind us of the double chain of ganglia on the ventral surface of the Articulata.

But are they truly analogous?

When one calls to mind the functions of those systems of nerves, it is clear that the sympathetic in man plays a very different part to the nervous system of the Articulata; the digestive and circulatory systems of this class of animals do not need nearly such an elaborate apparatus of nerves as the human sympathetic; whereas the numerous and rapid movements of locomotion and otherwise of these animals need nerves of the cerebro-spinal class.

M. Vulpian says "the Annelids possess as a central nervous system, a ganglionic apparatus, in which each ganglion is united to that which precedes it and to that which follows it by connections of various lengths." He continues "the spinal cord of the Vertebrates is nothing more than an analogous ganglionic apparatus in which the connecting links become obscure in consequence of the coalescence and the fusion of the ganglia." I believe, however, that it is no more correct to compare the nervous system of the Annelids to the spinal cord of the Vertebrates, than it is to compare it to the sympathetic system.

What would appear to be probably the truth is, that, in the lower classes of animals, the cerebro-spinal and sympathetic systems are united and that only in the higher classes are they differentiated. This, however, is disbelieved by M. Blanchard, who observes:—"from all the facts known concerning the nervous system of the Articulata, we may say that there are nerves of special sensibility, which arise in the brain; mixed nerves, sensory and motor, springing from the encephalon and ganglionic chain; a nervous system attached to the anterior portion of the digestive canal, to the respiratory organs, and the principle parts of the circulatory apparatus, and fulfilling the functions of the Vagus nerve, and, lastly, a true great sympathetic accompanying the ganglionic chain in its whole length."

I will now discuss shortly the Physiology of the Sympathetic; and will first treat of its action on the heart and bloodvessels. The heart contains ganglia of the sympathetic connected together by commissural fibres within its walls, and its rhythmical action continues, as you all know, when it has been removed from the body, but, nevertheless, the nerves which enter the heart from the cardiac plexus and which are derived partly from the Vagus, and partly from the sympathetic, exert an influence upon its movements.

As you well know, the fibres contained in the Vagus possess the power when irritated of slowing the heart; I would add, that these inhibitory fibres are probably really derived from the spinal accessory nerve.

Besides these centrifugal inhibitory fibres, the Vagus also contains other fibres which slow the heart, these are centripetal fibres, which arise from the heart and are contained in the Vagus or superior laryngeal nerve; in the rabbit they form a separate nerve, the ramus depressor of Ludwig and Cyon. These depressor fibres pass up to the Vasomotor centre in the Medulla Oblongata and by paralyzing its action cause a dilatation of the Aorta and visceral arteries, and by diminishing the intra-cardiac blood pressure lead to a considerable diminution in the force and frequency of the cardiac beats.

Besides inhibitory and depressor nerves of the heart, there are also accelerator and pressor nerves.

If the spinal cord be divided at the level of the

Atlas, and the lower cut surface be irritated, the heart beats more frequently.

The accelerating nerves, which are thus found to pass through the cord, are believed to proceed from the Medulla down the cord and to pass out by the lower cervical and two upper dorsal nerves, then through the rami communicantes to the ganglion stellatum and thence to the heart.

If both pneumogastrics, the cervical sympathetic, and the splanchnics be all divided, the accelerating influences is still exerted, but although the heart beats more quickly its force is not augmented.

If, however, the splanchnics be left intact, and all the cardiac nerves be destroyed, when the lower cut surface of the spinal cord is stimulated, there is not only an increase in the frequency of the heart's beats, but also in their force.

This is believed to be due to irritation of fibres passing down from the vasomotor centre in the Medulla to the splanchnics, hence causing contraction of the aorta and visceral vessels, and so, an increase in the heart's action.

The Vagus is believed by Schiff to contain accelerator fibres; it also contains centripetal pressor fibres.

I must now bring before your notice that function of the sympathetic nervous system, which, perhaps, has received the greatest attention of physiologists, namely, its action on the bloodvessels through the vasomotor nerves.

For a most interesting account of the vasomotor nerves, with a detailed account of the various experiments by which their action was determined, I must refer you to the number of the *British and Foreign Medico-Chirurgical Review* for last October.

From this article I have derived many of the facts, which I am about to detail or retail to you.

Every tyro in Physiology knows, and now that Physiology is taught in schools, one will soon be able to say "every schoolboy knows," that the circular muscular fibres of the arteries are in a state of tonic contraction, called arterial tonus, owing to the influence of nerves, usually believed to proceed from a centre in the Medulla Oblongata, and to pass through the ganglia of the sympathetic.

I have no time to give a detailed history of how these facts were discovered, but will give you a few facts gathered from the interesting article in the *Medico-Chirurgical Review*, which I have before commended for your perusal. I do so, as some of you might not have the time or opportunity of reading the article in question.

Claude Bernard in 1851, was the first to thoroughly arouse the attention of physiologists to the vasomotor function of the sympathetic.

Bernard's fundamental experiment of dividing the sympathetic in the neck had been performed before, even as far back as 1727, by Pourfour du Petit, and only a year before Bernard's researches, Budge and Waller had repeated and confirmed Petit's experiments; but the attention of these observers was only directed to the action of the sympathetic nerve on the pupil. It was left to the sagacity of Bernard to discover the congestion and rise of temperature.

Bernard, however, did not attempt to explain the mechanism by which the vascular turgescence was brought about, it was left to Brown-Séquard to show that the dilated conditions of the vessels was really due to paralysis of their contractile walls, and to assign the rise of temperature to its true course, namely to the larger volume of blood sent through the affected area in a given time.

The most important effects following section of the cervical sympathetic noticed by Brown-Séquard are: (1) Contraction of the pupil; (2) Almost all the muscles of the eye are contracted so that the eyeball recedes. [Later observers have noticed that there is convergent stabismus. You all remember that the 6th or abducent nerve, receives an unusually large branch from the sympathetic. It is an interesting fact that the muscles of the eye are almost, if not quite, the only voluntary muscles influenced by the sympathetic.] (3) When the cervical sympathetic is divided, the temperature of the same side of the head and neck is increased. Vulpian has noticed in the frog congestion not only of the corresponding half of the tongue, but of the entire buccal cavity of the same side; (4) sensibility is increased; (5) Perspiration (especially from the ears of horses) is increased and (6) a galvanic current too weak to act on the opposite side may produce contraction in the muscles of the affected side. Other facts of minor importance were also noted by Brown-Séquard. By galvanizing the distal end of the divided nerve, this investigator was able to show that all these effects were reversed, thus the pupil was found to contract, the dilated vessels returned to their normal calibre, or became even narrower, and the temperature fell. Other nerves of the sympathetic were soon found to have the same power of narrowing the arteries, thus, when the splanchnics were divided relaxation of the arterioles in the abdominal viscera was found to occur.

Owsjannikon determined the exact spot of the vasomotor centre by slicing the brain transversly from before backwards, the effect of each transverse section on the blood pressure being noted by means of a mercurial kymograph connected with the carotid artery.

The Vasomotor centre was thus found to be situated in the floor of the 4th ventricle, between the corpora Quadrigemiua and the calamus, but nearer to the former; it was also found that the Vasomotor centre did not occupy a median position, but consisted of two bilaterally symmetrical halves.

The Vasomotor nerves descending from the medulla Oblongata (also the "pressor" fibres proceeding to it), are contained in the antero-lateral columns of the cord.

(To be continued.)

STATISTICAL REPORT OF LYING-IN CHARITY FOR FEBRUARY, 1877.

Number of women attended			195
Recovered	195		
Died	0		
	195		
Single Births		192	
Dual		3	
		195	
Women attended in 1st confinement		23	
„ „ 2nd „		23	
„ „ 3rd „		41	
„ „ 4th „		19	
„ „ 5th „		19	
„ „ 6th „		17	
„ „ 7th „		19	
„ „ 8th „		12	
„ „ 9th „		8	
„ „ 10th „		8	
„ „ 11th „		4	
„ „ 12th „		1	
„ „ 15th „		1	
		195	
Children at full time.			
Males alive	104		
Males dead	4		195
Females alive	78		
Females dead	9		
Permature children.			
Males alive	1		
„ dead	0		2
Females alive	1		
„ dead	0		
Abortion			1
Total number of children			198

Alive	184		198
Dead	14		
Presentations.			
Vertex		175	
Breech		7	
Vertex and hand		3	
Brow		2	
Face		1	
Hand		1	
Shoulder		1	
Foot		2	
Placenta prœvia		1	
Abortion in membrane		1	
Not recorded		1	
		195	
Operations.			
Version	3		
Complete	2		
Partial	1		
	6		

Externs attended.	
Mr. R. F. Cox	25
Mr. J. Davies	35
Mr. O. Griffiths	37
Mr. M. T. Hart	24
Mr. C. J. Parke	37
Mr. West Jones	37
	195

JOHN TALBOT BRETT,
Junior in Charity.

SOLUTION OF DOUBLE ACROSTIC.
In the Gazette of March, 1877.

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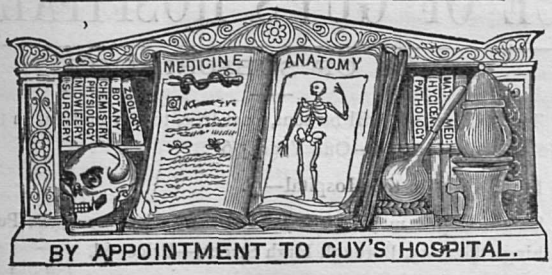

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THE SYMPATHETIC NERVOUS SYSTEM.

Read before the Physical Society 6th January, 1877, by R. S. WAINEWRIGHT. (Prize Paper.)

(*Continued from page* 48.)

At the level of the Bulb the vasomotor fibres cross each other, and in hemiplegia from a central cause the vasomotor lesion, as with the other lesions of the motor tract is observed on the opposite side to that of the encephalic lesion.

The vasomotors pass out from the cord by the anterior roots of the spinal nerves.

The height of the roots from which the vasomotor spring, does not at all correspond to the height of the organs, or of those parts in which these nerves are supplied, thus Bernard has demonstrated that the vasomotors, which join the Brachial plexus come to it by the ascending filaments of the thoracic cord of the sympathetic, and that those which join the sciatic nerve come by the descending filaments of the lumbar region cord; the former from much lower, the latter from much higher roots than those of the corresponding nerves, to which they are afterwards united.

As the vasomotors spread into the arteries, they follow an independent course in certain parts as in the neck and head; in other cases their arrangement exactly resembles that of the arterial branches, as in the abdominal sympathetic; in the limbs they unite with and are lost in nerves of the brachial and lumbar plexuses, etc., the union being made at a certain distance from the plexus; in the case of the Sciatic nerve, a little before it leaves the pelvis, and in the nerves of the arm, at the level of the brachial plexus.

The tonus or tonic contraction of arteries is usually thought to be due to a constant state of excitation of the vasomotor centre, which arises either from a continous reflex action originating in the sensitive nerves of the arteries, or, as some think, from the presence of carbonic acid in the blood circulating in the arteries of the medulla.

Thiry affirms that, if animals be poisoned by means of this acid, all the small arteries will be found in a contracted state.

Hermann remarks that the grey substance of the spinal cord contains proximate centra of a reflex nature, to which the descending vasomotors first proceed, and he believes that the cord shares in the tonic excitation of the fibres, for, although unilateral section of the cord causes dilatation of all the arteries of the same side, below the level of the section, yet the dilatation is not permanent, but soon gives place again to contraction. Moreover, poisoning by means of strychnia causes contraction of the arteries, which have been previously dilated by dividing the cord above.

Professor Goltz, of Strasburg, affirms that the tonus of the arteries is maintained by local centres, situated in their own immediate vicinity, and is wholly independent of the cerebro-spinal axis, and of the great chain of sympathetic ganglia. His opinion is based on the following fact, that the abolition of the arterial tonus in any vascular area is never permanent, and that the tonus is invariably restored after a certain time.

Many other Physiologists, including Hermann, believe in the existence of these perivascular centres.

It is probable, as stated by Professor Lister in a paper published in the *Philosophial Transactions*, as long ago as 1858, that the local co-ordinating apparatus, though capable of independent action under special conditions of direct irritation, is, under ordinary circumstances, in strict subordination to the spinal system.

Lately it has become the opinion of many physiologists that vasomotor centres are actually disseminated through the cerebral cortex; from many facts, which time will not allow me to detail, this seems highly probable.

Brown-Séquard some time previously had observed that thermal irritation or mechanical injury of the cerebral surface, might be followed by most of the effects which usually result from section of the cervical sympathetic. Up to the present time I have spoken only of vaso-constrictor nerve fibres, but, undoubtedly, as proved by many interesting experiments, there are also vaso-dilator or more properly vaso-inhibitory nerve fibres.

That such fibres exist has been accepted by such eminent physiologists as Goltz, Vulpian, Schiff and Stricker. Goltz goes so far as to say that the vascular relaxation consequent on division of nerves, is invariably due to irritation of vasodilator, and never to paralysis of vaso-constrictor fibres.

Time allows me to give only very few examples of the action of vaso-inhibitory nerves.

The Submaxillary gland, as you all know, receives its nervous supply from two distinct sources, from the superior cervical ganglia of the sympathetic, and from the chorda tympani through the medium of the lingual nerve. Both sets of fibres are in connexion with the bloodvessels of the gland, but they exert a precisely opposite influence upon their calibre. Stimulation of the sympathetic filaments causes constriction; stimulation of those derived from the chorda tympani dilatation of the vessels.

The dilatation produced by electrisation of the chorda tympani, is said to be greater than that produced by paralysis of the sympathetic fibres.

M. Vulpian has noticed that the vasodilator action of the chorda tympani is not confined to the vessels of the submaxillary gland, but extends to the anterior portion of the tongue likewise.

Another example is found in the nervi erigentes, first described by Eckhard; they arise in the dog from the sacral plexus, they then enter the hypogastric plexus and terminate in the corpora cavernosa.

If the nerves be cut, and their peripheral ends

stimulated by the galvanic current, the corpora cavernosa became turgid with blood, and one of the proofs that this is due to dilatation of the arteries and not to compression of the veins, is, that partial erection may be caused by electrisation of the nervi erigentes, even when the efferent veins have been freely opened.

Holmes affirms that when the central end of a divided auricular nerve is excited by feeble induced currents, congestion of the corresponding ear follows in a period, which varies from 3 to 6 seconds. This congestion is more intense than is produced by section of the sympathetic, and is accompanied with obvious dilatation of the arteries.

It would appear to be more correct to call these nerves vaso-inhibitory rather than vaso-dilator, as they probably act upon local perivascular centres, and not on longitudinal muscular fibres in the arteries; indeed, the existence of longitudinal muscular fibres in the arteries, is doubted by some physiologists (*e.g.* Küss).

Another interesting theory of Legros and Orimus I have barely time to touch upon.

These observers believe that there is a constant peristaltic action of the muscular fibres of the arteries, by which the blood is continually propelled onwards. They believe that it is due to this peristaltism, that the arteries are found empty after death.

They also declare that direct inspection of the small arteries reveals this peristaltic contraction; thus Orimus says "If the central artery of the retina be obstructed by a clot, we see by the aid of the ophthalmoscope, the small arteries which shew the existence of a collateral circulation, have very marked peristaltic movements.

The emptying of the arteries after death is believed by other observers to be due to the persistent activity of the vasomotor centre after the heart has ceased to beat.

Besides the muscle of the heart and the smooth muscle of the arteries, the sympathetic nerves supply all other smooth muscles; thus the dilator fibres of the Iris and the Orbital muscles of Müller are supplied by the sympathetic.

The muscles are in a state of tonic contraction, which ceases on section of the sympathetic cord in the neck.

The automatic centre, occulo-spinal or cilio-spinal, which regulates this tonic contraction, is situated in the spinal cord, in the neighbourhood of the lower cervical and upper dorsal vertebræ, but this centre is merely the proximate origin of the fibres to the eye; the real centre being in the medulla oblongata, and closely connected with the vasomotor and respiratory centres.

The sympathetic nervous system supplies the stomach and intestines, the bladder and uterus, and the unstriped muscle of other organs; it supplies secretory nerves to glands, and probably directly influences nutrition.

All the alimentary canal below the pharynx undergoes a peristaltic contraction, probably immediately due to a reflex action through a chain of nerves and ganglia situated in its walls, some think that the solar plexus is the centre of these reflections.

In the small and large intestines there are two plexuses, one, described by Meissner in the submucous areolar tissue, the other which has been shewn by Auerbach to be between the circular and longitudinal muscular fibres in the small intestines, and on the outside of the longitudinal layer in the large intestines, the peristaltic action is, however, influenced by nerves which come from the brain and spinal cord.

Schiff and Budge obtained intestinal movements in cats, by irritating various parts of the brain.

Also if the roots of the spinal nerves be irritated, there is peristaltic contraction, these fibres are found to pass through the ganglia of the sympathetic, before reaching the intestine.

Some observers have remarked contractions, not only of the stomach, but of the small, and even of a portion of the large intestine on electrisation of the vagus in the neck. The splanchnic nerves have a remarkable influence by inhibiting the movements of the intestine.

Nasse believes that they contain proper motor mingled with the inhibitory fibres, but that the latter are much the more powerful, these peristaltic actions go on in health without the mind being conscious of them, but the sensibility of the intestines is acutely manifested in morbid states, in which the impressions seem to be propagated further than usual in virtue of their great potency.

The sympathetic ganglia seem to have the power of reflecting the ordinary gentle impressions received, but if the impressions are stronger, they are not reflected, but pass on through the sympathetic ganglia to the spinal cord and brain.

I will now say a few words regarding the action of the sympathetic on secretion.

The secretion of the submaxillary gland has been most fully investigated.

I have before mentioned the vasoinhibitory action of the chorda tympan nerve on the vessels of this gland, and the vaso constrictor action of the sympathetic. Besides sending nerves to the bloodvessels, both these nerves send proper secretory fibres to the gland.

Heidenhain found that Atropia paralysed the secreting fibres of the chorda tympani, whilst the vasodilator remained intact.

The saliva secreted under the influence of the sympathetic is tough and gelatinous, and very rich in mucus, whereas when the chorda tympan is irritated the saliva is copious, and as it contains but small quantities of specific constituents is very fluid.

The salivary secretion is brought about reflexly; when stimulation proceeds from the nerves of taste or from the stomach, the centre for this reflex action is in the medulla.

In the case of stimulations other than gustatory

applied to the mucous membrane of the mouth, the centre of reflection is the submaxillary ganglia.

This is proved by the fact that after section of the trunk containing the chorda tympani and lingual nerves, stimulation of the former kind no longer produce any effect, while those of the latter kind operate as usual.

Thus the submaxillary ganglion is a centre presiding over secretion.

As regards this Hermann remarks "the only apparently established fact indicating the existence of reflex powers in a ganglion [of the sympathetic], viz., the secretion of saliva, induced in a reflex manner through the submaxillary ganglia has recently been doubted by Eckhard: for the result follows an electricial stimulation only, and may be due to a diffusion of the current, which may thus affect the secreting nerves themselves."

With regard to the influence of the sympathetic on gastric secretion, it appears to have been settled, though there has been a good deal of disagreement in the experimental researches on this point, that the secretion of gastic juice does not *depend* upon external nervous agency, for both the vagus and the sympathetic nerves may be divided and still secretion continues, but that these nerves have an important *influence* on the gastric secretion is evident from the deficiency in its amount soon after their section, as well as from other facts.

I will now pass on to some pathological effects due to the morbid action of the sympathetic nervous system.

Cases often accur in which the cervical sympathetic is pressed upon by an aneurism, or other tumour; its paralysis is recognised by the heat and flushing of the same side of the head and neck, and by the contraction of the pupil.

Dr. Dickson, our late lecturer on mental diseases, in an interesting article in the *Lancet* on "Sympathetic depression and emotional disturbance," gives an account of one disease which so greatly affects the sympathetic nervous system, that most marked appearances of change and degeneration are seen post-mortem. The disease in question is paralytic dementia, and he thus decribes it: "In this form of disease the ganglia of the sympathetic are wasted and disorganised and contain a deposit of black pigment. The patient exhibits during life various states of emotional disturbance very characteristically, but the fact of finding this coarse change in a profound disorder, gives some promise of discovery of more subtle changes in less severe conditions."

Up to the present time, however, I am afraid very few discoveries have been made of changes and degenerations in the ganglia of the sympathetic, This is doubtless in great part due to the want of a proper amount of investigation.

How often for instance, at our post-mortem room at Guy's have any of you, gentlemen, seen an investigation made to see if the sympathetic ganglia were in a healthy state or not? The reasons why the sympathetic ganglia are so little studied in the post-mortem room, I believe to be two in number; (1) the study of these bodies is attended with considerable trouble, and it needs time and care in order to make a sufficient microscopical examination of them, and (2) the notion, I may say the absurd notion, which has obtained so much of late years, that all the sympathetic nerve fibres are derived from the brain or spinal cord, and that the sympathetic nervous system is but an offset of the latter.

Of what use then, I would ask, are the ganglia, more than seventy in number, and many of large size, ranged so regularly along the front of the vertebral column?

Surely it is quite in accordance with our knowledge of the function of ganglion cells to believe that each of these ganglia preside over some reflex processes, though what precisely these may be it may be impossible as yet to say.

Another proof that this is so, is that it is believed by the best authorities that more fibres pass out of the sympathetic ganglia than can possibly be derived from the brain and cord. Time forbids me to give you an account of the various experiments from which this conclusion is drawn.

I believe that another reason why so few discoveries have been made of changes and degenerations which have gone on in the sympathetic ganglia during life, is, that very many of the affections of the sympathetic nervous system are functional and not organic.

Dr. Richardson considers that the various hysterical symptoms are due to some abnormal excitement of this system of nerves. He says, further, to use his own language, "the organic nervous centres are the centres of those mental acts which are not volitional, but are instructive, impulsive, or, as they are most commonly called emotional, the centres of that primitive nature within us, which we know to be distinct from the more flexible governable nature, which is commonly called the reasoning nature, and which is seated in the brain and in its subsiliary parts. We are all conscious of these two natures, and, what is more, we are not only conscious of them, but we refer the emotional nature to its true seat. We say of sorrow, 'It sits heavy on the heart,' and the glow of pleasure or the gust of fear are each immediately conveyed to us by sensations distinctly referable, not to the reasoning brain, but to the organic nervous cord."

Numbers of the small discomforts, which are daily experienced by everyone, are due to functional disturbances of the sympathetic system; thus the organic ganglia may be acted upon by indigested food, or bile, or decomposing secretions remaining in the alimentary canal, also congestion of the great visceral organs of the abdomen may cause pressure upon them; some-

times the pressure comes from without, as in writing, the body gets pressed against a desk, or in reading, the the heart gets pressed upon. These functional disturbances are shewn by flushes, chills, and as Dr. Richardson adds, "coldness of the extremities, perspirations, irregular action of the bowels, deficient tone in the stomach and intestines, with flatulency as a constant and oppressive symptom, and often a copious diuresis of a perfectly colourless secretion. At times, distressing, and even painful ringing sounds in the head. These sounds are arterial murmurs, caused by the effect of pressure upon the relaxed arteries"

Other symptoms are a sudden sensation of numbness in a limb or in the lip; perturbed muscular action, such as the twitches of the muscles just on going to sleep; and the curious muscular quiver called "live blood." Such as these are the symptoms indicating reduced arterial tension.

Professor Küss believes that the chief way in which feverishness is brought about, is a derangement of the vasomotor nerves paralysing the vessels and producing a change in the regulation of the heat of the body.

He affirms that Digitalis has the effect of lowering the pulse and diminishing heat, and is therefore a powerful agent against fever.

Its mode of action he considers to be as follows: besides retarding and regulating the motion of the heart, digitalis also acts on the peripteral organs of the circulation, causing contraction of the coats of the arteries, by exciting the vasomotor nerves. That digitalis does cause contraction of the arteries has been disputed by many observers, but Dr. Brunton having reinvestigated this question, with the aid of Traube's modification of Ludwig's kymographion, holds to his original view, that digitalis does cause contraction of the arterioles.

Ackermann believes that he has proved that this contraction of the arteries is due to an excitation of the vasomotor nerves.

Professor Küss thus concludes that the power of digitalis as a remedy in fever, is due to its having the power to restore the contractility of the small arteries under the influence of the vasomotor nerves.

It is found that injury of a limited space in the medulla oblongata in the floor of the fourth venticle, produces diabetes, the traumatic diabetes of Bernard. This spot is possibly a portion of the vasomotor centre.

Hermann says "Diabetes may arise either from a conversion (or increased conversion) of the glycogen of the liver, or of other organs into sugar, or from a diminished conversion of ingested sugar into glycogen, or thirdly from a diminished destruction of the sugar normally originating in the glycogen of the liver."

Hermann believes that both traumatic and pathological diabetes, depend upon the incapability of the liver to arrest the sugar which is brought to it, and to convert it into glycogen, so that the sugar passes unchanged into the urine or accumilates in other organs.

According to Schiff, Cyon and Aladoff, the proximate cause of traumatic diabetes is a paralysis of the bloodvessels of the liver.

Besides puncturing the floor of the fourth ventricle, injury of the inferior cervical ganglia of the sympathetic, or of the nerves which proceed from it to the ganglion stellatum, occasion diabetes; there are also fibres in the splanchinc nerves, which when irritated cause sugar to appear in the urine.

Œdema may be produced by paralytic dilatation of the small arteries, as this increases the efflux of blood, and consequently, the pressure in the capillaries.

Paralysis of the vasomotor nerves appears to be the cause of dropsy, which takes possession of the limb which has undergone section of the sciatic nerve.

Brown-Séquard considers that the loss of consciousness, which occurs in simple vertigo, or in complete attacks of epilepsy, does not depend upon a disease of the brain, but upon a contraction of the bloodvessels of the cerebral lobes, which contraction is due to some irritation of the vasomotor nerves of these vessels, either by some direct cause irritating them in the base of the encephalon or the spinal cord, or by a reflex influence.

Van der Kolk also considers that one of the causes of epilepsy is an abnormal irritation of the sympathetic nerve.

He believes that the best medicine to subdue such irritation is Belladonna.

I will conclude by referring to an interesting disease, which is supposed to be due to paralysis of the vasomotor nerves of the vessels of the heart, thyroid body and head and neck.

I refer to exophtholmic or anæmic gôitre, called also Grave's disease. It occurs chiefly in women with marked anæmia and menstrual derangement.

The disease is characterised by enlargement with vascular turgescence of the thyroid gland, accompanied by protrusion of the eyeballs, anæmia, and palpitation of the heart and carotid arteries.

No change has as yet been discovered in the cervical ganglia of the sympathetic after death.

CASE OF HERNIA OF OVARY.—EXCISION.

Lucy W., æt. 19, a domestic servant. Has always enjoyed good health. Had been confined two years before date. Last November on rising one morning after a day of unusually heavy household work, she noticed a painful swelling in the right groin, and the same day had severe vomiting which lasted several days. She came to Mr. GOLDING-BIRD'S out patients and remained under his care for some weeks.

Mr. GOLDING BIRD diagnosed a hernia of the Ovary at the internal ring, and confirmed his diagnosis by

observing that the tumour was much congested during a menstrual period.

The patient was admitted into Martha 13, March 6th. On admission, at the situation of the internal abdominal ring is an ovoid tumour about 1½ inches by ¾ in, very painful upon pressure, more prominent in the erect position and giving a marked impulse upon coughing. To the touch it is much like a somewhat indurated gland. She was carefully watched through one menstrual period, and a distinct increase in the size and vascularity of the tumour observed. This subsided on the cessation of the catamenia.

March 20th, Mr. GOLDING-BIRD excised the tumour. An incision was made over the situation of the internal abdominal ring and the oblique muscles divided. The tumour was found to be firmly adherent to surrounding structures, especially to the internal oblique. A cord passing towards the external ring (presumably round ligament) was ligatured and divided, and the tumour being tilted up and further separated from its adhesions, was found to be attached to a pedicle apparently emerging from the abdominal cavity. This was also ligatured and divided and the tumour removed. No peritoneum was seen. The cutaneous tissues and muscles were then brought together by sutures.

21st.—Pulse, 104; temperature, 101°. Much vomiting apparently from the anæsthetic. ℞ Acid Hydrocyan Dil ♏iii. Ex. Mist. Ammoniæ Effervescentis ℥j. 4tis horis.

22.—Pulse, 108; temperature, 102·1°. Vomiting has ceased. Much less pain. Wound dressed antiseptically twice daily.

23.—Pulse, 104; temperature, 102°. Sutures removed. Very little pain. Profuse suppuration. No abdominal symptoms.

24.—Pulse, 100; temperature, 100·1°. Slight catamenial flow has appeared this morning. The normal period is three weeks distant.

The menstrual flow lasted 4 days. For some weeks profuse suppuration continued, but has now ceased and been succeeded by healthy granulations. The wound is rapidly healing and the patient is making a good recovery.

Under the microscope the tumour shews a fibrous structure exactly like ovarian stroma, but no Graafian vesicles are perceptible.

The points of interest about this case are, the rarity of similar cases, the periodic congestion of the tumour and the occurrence of the catamenia at an abnormal period, 4 days after the operation, a fact coincident with what is observed after other operations upon the ovary. These facts tend strongly to confirm the original diagnosis. The absence of Graafian vesicles was observed in a similar case recorded by Dr. ALFRED MEADOWS, and probably depends upon a degeneration of fluid structure, extremely likely to occur in an organ so long confined in an abnormal position.

W. DARLEY HARTLEY.

A CASE OF POISONING BY BURNETT'S DISINFECTING FLUID.

Some time ago two cases of poisoning by Burnett's fluid appeared in the *Guy's Gazette*, and as this differs in some points from them I thought it might be interesting. The disinfectant in Burnett's fluid is Chloride of Zinc, at once a Caustic and Emetic. Its emetic properties renders it from any effect comparitively harmless. It is afterwards that œsophageal and gastric symptoms develop, and it is these that are to be feared.

A.M. æt. 31, being depressed by heavy money losses, at ten o'clock on the morning of April 26, took about four ounces of the above fluid. Five minutes after taking it he began to vomit violently, and in ten minutes passed frequent copious watery stools. The diarrhœa and vomiting continued until three o'clock in the afternoon, when he was admitted into Clinical under Dr. TAYLOR. On drinking the fluid he experienced a burning sensation in the throat and soon after complained of severe epigastric pain.

When admitted he did not appear much collapsed, but complained a good deal of pain at the pit of the stomach. He was vomiting light brown frothy mucus streaked with blood, and passed quite liquid watery motions. The tongue was furred but did not show any signs of erosion. The throat was red and injected, and the fauces were whitened, uvula, also much swollen. He was very thirsty.

Temperature, 97·8°; Pulse, 128. He was ordered ℞ Mist. Effervescens ℥j. Pil. Opii gr.j 4 tis horis, and was to take milk and ice. The vomiting ceased the same evening, and the diarrhœa the next morning. Dr. STEVENSON analysed the vomit and found Chloride of Zinc in it.

The abdominal pain diminished and patient went out of the hospital in charge of a police officer, April 30th. He was seen again ten days afterwards, when he was still unable to take any solid food owing to the pain it causes him.

C. KNOX SHAW.

ON DUTY FOR MAY.

House-Physicians:—W. A. Kidd, M.B., T. L. Porter, M.B.
Senior House-Surgeon:—M. Lubbock, M.R.C.S.
Junior House-Surgeon:—W. P. Reynolds, M.R.C.S.
Senior in Charity:—A. Lacey, M.R.C.S.
Junior in Charity:—W. C. James, M.B.

DRESSERS FOR THE WEEK.

May 2nd, Mr. T. Judson (Mr. Durham).
„ 9th, Mr. H. Davy (Mr. Howse).
„ 16th, Mr. Wright (Mr. Forster).
„ 23rd, Mr. Meek (Mr. Bryant).
„ 30th, Mr. Hammersley, (Mr. Durham).

Cricket.

RICHMOND *v.* GUY'S HOSPITAL.

This match was played at the Old Deer Park on Wednesday, May 9, and won by the home team by 57 runs. Messrs. Chapman, Stokes, and Bryden, played well for the visitors as did J. S. Russell, Hill, Yerburgh, and Fox for the home team. Mr. Hill's innings being a very fine piece of cricket. Score:

GUY'S HOSPITAL.		RICHMOND.	
V. Chapman, l b w, b Fox	47	J. S. Russel, b Earle	28
J. H. Earle, c J. Robertson, b Fox	9	J. Wilkes, b Veitch	4
L. Stokes, b J. Robertson	35	H. Studd, c Chapman, b Earle	8
F. J. Fehrsen, run out	3	W. Furze, b Veitch	6
J. A. Fraser, b J. Robertson	7	H. J. Hill, c Keer, b Bryden	50
H. G. Ashwell, b Fox	0	R. E. Yerburgh, c Ashwell, b Veitch	24
Q. R. Veitch, b J. Robertson	0	T. C. Fox, b Veitch	44
R. J. Bryden, c J. Robertson, b Yerburgh	15	Hon. H. J. Tollemache, c Fehrsen, b Earle	8
S. Lee, b J. Robertson	9	J. Robertson, l b w, b Veitch	12
F. S. Willett, c Russel, b J. Robertson	0	C. Marshall, b Earle	5
J. C. Keer, not out	0	F. S. Robertson, not out	0
Byes 25, l-b 5, w 9	39	Byes 18, l-b 5, w 5, n b 4	32
Total	164	Total	221

GUY'S HOSPITAL GAZETTE, *MAY*, 1877.

THE summer session apparently does not bring as much work with it as the winter one. As regards the junior men this is notably the case, for the study of anatomy and physiology well fills up the first two winters, accompanied as it is with so much practical work in the shape of dissecting and demonstrations; the summer brings temporary relief from bones and "parts," and the only danger is lest too much rest be taken in this direction, necessitating an almost absolutely fresh osteological research when the next winter comes on. Those who have passed the College "primary" certainly deserve a rest, and they will probably take it, let us hope that they may chew the cud of successful work while taking their brief *otium*; it is a great satisfaction to look back on hard and successful work, and we congratulate the heroes of the "first batch," who have shewn such a good example. But it is more especially the first year's men who does not know quite how to fill up his summer; some although they do not appear at the hospital regularly, are well employed, for perhaps they play cricket, and matches, are plentiful; others for the nonce become amphibious, and many stories they can tell of delightful rows and campings-out at night. But the working division, if it be right so to call them, do not find it so easy to fill up their time well. Those who are looking forward to the Preliminary Scientific, or 1st M.B., in July, of course do not complain of too much time, the fine summer afternoons are well spent in the Comparative Anatomy museum, and museum of Materia Medica, and the bright sunny mornings are enjoyed in the Practical Chemistry laboratory with a glass roof. But the great majority of men have no examination in view at the end of the summer, yet the three summer months and even August and September, may be spent most profitably, and certainly pleasantly too, in the study of Biology, without some knowledge of which no medical man can pretend to be well educated. The student of medicine in commencing with the study of *human* physiology begins, we think, at the top of the tree, for that branch of knowledge treats of the highest manipulations of life, about which it is impossible to have an intelligent idea without a knowledge of the lower and simpler which shall lead up by degrees to the highest. Certainly in the course of lectures on general physiology attention is drawn to the life history of cells and other organisms, but it does not come within the scope of such a course to examine any class more particularly: yet the opportunity to do so here is afforded every one, for not only is there a course of lectures, with drawings and preparations, but also the abundant collection in our museum serves exceedingly well to make the reading of Nicholson and Huxley both intelligent and delightful. Again, if August and September are to be spent in the country or at the seaside, there would be in that case, still greater opportunities of becoming practically acquainted with the facts of Biological science, a subject second to none in its importance to us.

FROM one source and another we have lately been hearing a good deal about the unpractical tendencies of medical education and medical students. It may, therefore, be interesting to enquire how far we alone are to blame, and how far our tendencies differ from those common to our time. We see the embryo legislator, for instance, go to Oxford to seek in the study of Cicero and Thucidydes for that knowledge which will help him to deal with intemperance or vivisection; whilst, lower down in the scale, a child, whose future as an artisan's wife will be spent in housework, goes to a board school to learn decimals, and afterwards to ruin her children's constitutions by her utter ignorance of the mere rudiments of cooking. The great aim then of the age appears to be the teaching of knowledge to an individual which will be utterly useless to him in his ordinary life, and we may, therefore, take heart when *wise* authority decrees that a consummate knowledge of the anatomy of an earthworm is of the utmost importance to a scientific physician. Our profession, at any rate, is no worse than others; and would it not be a mistake if we alone were practical in the midst of an unpractical age? But all this is so strangely different from the sort of thing which made the great physicians of the past, our Brights and our Addisons,

that we may push enquiry farther to try and find some reason for the change. Side by side with this love of the unpractical has grown up an ever increasing scepticism, which defies all traditions of the past, leaving to antiquaries and chinomaniacs the reverence for everything old. A scepticism which sneers at all the old methods of treatment, which its own narrow experience in half-a-dozen cases does not prove to be correct, and which hands over to homœopaths and quacks the belief in the curative powers of drugs with the exception of Aqua Menth Pip and one or two more.

We would urge that the unpractical tendencies of our profession are but a natural result of such scepticism; and that in medicine, as in religion, scepticism will destroy the foundation on which all the practical part is to be laid. For, given that an expectant treatment is to be universally adopted, given that only some half-dozen drugs have any beneficient actiyn, and thoughtful students will turn from medicine as from a disgusting sham, while honest men will think a long time before they enter a profession which prostitutes itself to take fees from the sufferers whom they know they cannot benefit. And yet to hear many men talk one would think that the only safe practice was to put patients "*under the best hygienic conditions*," and give them "*bread pills as placebos*;" and, with this idea in their heads, what wonder is it that students turn to abstruse questions in pathology and physiology to supply papulum for their intellectual activity. Luckily for medicine this scepticism has as little foundation in fact as it is hurtful in practice. To gain a proper knowledge of when to use opium would alone take ordinary students their life-time, while an increased knowledge is teaching us how to control the sweats of phthisis and the temperature of the fevers. But the question arises whence comes this scepticism in the minds of students? This we will not venture to answer, but that it exists is, we think, certain. Certain too it is that neither books nor professors definitely teach it; and, therefore, it is probably one of those unverified delusions that men think when they believe that men greater than themselves hold such and such opinions. Yet further, how is it to be combatted? This we think rests with our clinical teachers. If, instead of spending hours in discussing the brilliant diagnosis of an interesting but obscure case which the class will never see again (in focussing, for instance, a cerebral tumour to the exact square millimetre which it occupies), physicians would more often discuss the plans of treatment to be adopted in the cases which have been diagnosed, with the facts which cause them to prefer one plan more than another, or the symptoms which require the adoption of various measures. Students would gain a firm basis on which to act in after life. Although most undoubtedly an accurate diagnosis is of the very greatest importance, we should remember that our patients care only for the success of our treatment; and although the latter will be successful in proportion generally to the skill with which we have made the former, our success in life depends more on the latter. Let us students learn a little more of the faith in treatment which buoyed up our physicians in the past and leave our scepticism until stern fact has forced it on us. This time and experience, perhaps, will teach us all too soon; but, in the meantime, we shall have learnt the practical part of our future life in its battle with disease.

MEDICINE AND BIOLOGY.

BY AN OLD GUY'S MAN.

Much do I rejoice in being a Guy's man and in the thought that I shall never cease from being one. Of the causes of congratulation among us this is not the least, that our teachers are so accessible. The juniors learn to feel that their seniors are but students of larger growth—that, though now mellow and ripened, they had their days of leafing and unripeness. The word *professor* is unfamiliar at Guy's, and there are no high walls of *professordom* that the pupils may not see their teachers sending their roots into and sucking up nutriment from the same soil. Yet we juniors do not the less respect our teachers because they sometimes let us put in our "little oar," and rub off our crudities against them. I think that we Guy's men respect our seniors and ourselves the more for the privilege, and that *bumptiousness* is not a characteristic of the men of Southwark.

It is on the strength of these reflections that a senior student presumes to address his fellow-students on a subject of so great interest as this, and wherein he may be led into what may amount almost to a criticism on what his former chief and present teacher has said on the same subject.

I have before me three separate speeches by three different men under distinct circumstances but relating to the same subject of discussion.

First comes JAMES HINTON, in our old Anatomical Theatre, on opening day, 1873. Next Professor HUXLEY, opening a new university in Baltimore, published in *Nature*, October 19th, 1876. Last Dr. MOXON, at the Hunterian Society.

In the light of these three we can, I think, see the subject all round. Professor HUXLEY deals with what more directly concerns the student, namely, his course of study. Dr. MOXON's Hunterian oration in part covers the same ground, in part deals with dangers in one direction. JAMES HINTON does not touch ground in matter-of-fact, neither does he dwell on the dangers of over-much science, but shows how medicine stands to all other knowledge, thought, and action.

I think that if we pursue this enquiry in the spirit of the speakers and dwell not too much on their letter we shall obtain a fair view of the question.

First, then, for the practical part of the subject. Professor HUXLEY, in that part of his address which more particularly relates to medical education, points out that the object of it is "to enable the practitioner, on the one hand, to prevent disease by his knowledge of hygiene; on the other hand, to divine its nature, and to alleviate or cure it by his knowledge of pathology, therapeutics, and practical medicine." To be competent for these duties he cannot dispense with a thorough knowledge of these things, though he were "the best anatomist, or physiologist, or chemist that ever took a gold medal." Yet a young man fresh from school is abruptly introduced to studies and a train of ideas, for which he has, for the most part, had no previous training, and is expected in a term of four years to acquire such knowledge of anatomy, physiology, therapeutics, pathology, hygiene, obstetrics, surgery, and medicine, together with the laws of evidence and medical jurisprudence, besides the nature and symptoms of mental diseases, that he may be ready and competent for action in any of his peculiar duties whenever he may be called upon to exercise them. The burden of the student of medicine being so great, it requires some care, he thinks, "to prevent his intellectual back being broken."

The Professor goes on to say that he has omitted from his already lengthy catalogue such subjects as botany, zoology, and materia medica, and that he has done so advisedly, for he thinks them not only superfluous but mischievous as curtailing the time afforded for subjects which directly bear on practical duties. "All knowledge," he says, "is good. It is impossible to say that any fragment of knowledge, however insignificant or remote from one's ordinary pursuits, may not some day be turned to account. But in medical education, above all things, it is to be recollected that in order to know a little well, one must be content to be ignorant of a great deal." The Professor thinks that there ought to be sound elementary science teaching in all ordinary schools, so that a student coming up to his professional studies should not be utterly unfamiliar with the processes of nature, or untrained in observation and manipulation. He thinks that a preliminary year should be spent by the student in acquainting himself, with the aid of "duly arranged instruction, combined with work in the laboratory, upon the leading types of animal and vegetable life," not with botany and zoology as systematic sciences, but with "the phenomena of life in their broadest acceptation." The student would thus "come to his medical studies with a comprehension of the great truths of morphology and physiology, with his hands trained to dissect and his eyes taught to see."

This coincides with much that Dr. MOXON says, so that Professor HUXLEY does not come under the Doctor's censure as far as medical education is concerned.

Dr. MOXON's remarks on HUNTER's habit of scientific forethought were, I think, borne out by what I once heard from HUXLEY's own lips. It was to this effect:—"do not suppose that a hypothesis is a thing you are pledged to support through thick and thin for the rest of your natural existence, but rather that in the light of which you may discern facts of significance, which will either establish your hypothesis or compel you to lay it aside."

My impression of Professor HUXLEY, from what I have heard and seen published of his, was of a man with an eye to principles and the significance of facts.

It seems to me that Dr. MOXON throws not a cheerful light on the condition of the rank and file of workers. HUNTER towers over a century of distinguished men, and what hope is there for those on a dead level? What are we to do? Wanting insight we must not follow the many enticing green lanes that lead to nature-knowing but away from professional duty. We, then, who are not seers but ordinary mortals, must be content to make diligent use of our time and heap up clinical and pathological facts, or at least sorting them with as much intelligence as we can. It is not for us to "see the essential point and leave the rest as surplusage." Yet I see a gleam of hope! BRIGHT never speculated but worked at kidney-disease, among other things, though Dr. WILKS doubts if he ever fully appreciated the importance of his discoveries.

It is hardly fair, I think, to make HUNTER's mode of work a complete criterion for the present. He was not in danger of being smothered by the dusty work of his contemporaries and was not encumbered by their heaps. His was the place of a pioneer in a new territory to mark out hills and valleys and rivers, to pick out the best wooded or best watered parts. Smaller troubles raised by his successors need not trouble him. Beaten roads and fashions and competitions are not yet. Nevertheless, I, for one, feel truly grateful to Dr. MOXON for evoking the spirit of HUNTER to bid us not forget Vital Principle, for she ever shuns beaten tracts and fashions and competitions.

It may be my want of experience or of discernment, but, from whatever cause, I do not find myself able to endorse Dr. MOXON's implication that vital principle favors only the votaries of medicine.

JAMES HINTON believed in vital principle, but, to him, it dwelt not Archæus-like in man alone, but was one with nature itself. And nature was not the spirit of plants and animals only, but of all things; not less, but more than we thought it. Nature, then, being the *fact* that ever lurks behind the phenomenal, no study of the phenomenal in this spirit should be counted unworthy. We doctors are students of biology in its broadest sense. We have an epitome of nature before us, the "circle of the completest individual life;" and, though we cannot travel all paths, we should take up what others have found, or think they have found, in theirs, and, comparing them with our own, correct the conclusions of us both if needful. The "supple vigour of an organic process" is constantly recurring to us, and is helpful to us and to others who are in danger of letting the reality slip through the holes in their negations, as *Pilocereus Senilis* puts it.

We study a *microcosm* while we try to help men and women in their troubles, but our end is with the *cosmos*.

INTRA-CRANIAL HÆMORRHAGE DUE TO INJURY. TREPHINING. RECOVERY.

Charles Denmark, æt. 14, was admitted into Accident ward under the care of Mr. DURHAM, at 9·30 p.m. on March the 9th, having half-an-hour previously fallen off the driving seat of a Railway Parcel van. When seen he had a scalp wound about an inch in length, on the back of his head close to the external occipital protuberance. On examining wound with finger the nail caught against a groove giving one the idea of fissure of the bone, Mr. GOLDING-BIRD, however, thought it due to division and turning up of pericranium.

The boy was in a semi-insensible irritable condition. Pupils not unusually contracted or dilated, and responding readily to light. The wound was covered with dry lint and patient put to bed. Temperature, 100°; pulse, 80.

March, 10th. Temperature, 100°; pulse, 76°. Patient remains in much the same stupid irritable condition as on admission. Bowels open. Answers when spoken to but in a most incoherent manner.

March, 11th. Still in the same condition, crying out at times complaining of pain in the head. The bowels have been open after two doses of calomel. He is lying curled up on his left side with his legs drawn up into his abdomen, and complains if they are straightened by nurse. The whole surface of body seems to be hyperæsthetic. There is no paralysis or twitching of any muscle, and the pupils are quite normal.

During the two following days he continued to get slowly worse, there being, however, no fresh symptoms to note, but only an intensifying of the primary conditions.

On March 14th, five days after the receipt of injury, a large fluctuating swelling was discovered on the occiput to the left of the wound which had now been closed for two days. [Unfortunately no note was made at the time of admission as to the condition of the surrounding parts, but my impression is that there was some blood swelling at the spot now mentioned, when he was brought to the hospital. A. G. B.] The wound itself is quite sound, there being no surrounding swelling or hardness. Pulse, 48; temperature, 99. At 5 p.m., he was seen by Mr. GOLDING-BIRD, in the absence of Mr. DURHAM. At this time the patient's condition had not altered in character, but the previous symptoms were more marked. He was still in the same semi-insensible restless condition, muttering and crying out at intervals. He would put out his tongue when asked to do so. The right pupil was thought to be larger than the left, while both responded readily to light. No paralysis twitching of any muscle was noted. No stabismus.

At 10 p.m., the patient was seen by Mr. DURHAM and Mr. GOLDING-BIRD together, the mental condition was much the same, but there were now added to previous symptoms very evident diminution of resistance in the right extremities accompanied by twitchings apparently rhythmical, of all muscles of right arm and also of both masseters. The right thumb was tightly flexed into the palm. There was no drawing of face and no squinting. The condition of the pupils at this time was not noted. His breathing was stertorous and accompanied by frothing at the mouth. It was now decided to incise the swelling previously mentioned; which having been done a quantity of fluid blood escaped from beneath the scalp. There was no pus. Though the pericranium was separated from the subjacent bone for some distance around, this opening (the bone) had quite a normal appearance. Mr. DURHAM observed that at one spot it appeared as though the blood was still oozing from the bone. The twitchings, at first somewhat increased by incision, became less afterwards and finally disappeared. The hemiplegic condition still persisted with other symptoms.

Mr. GOLDING-BIRD now proceeded to trephine through the incision made crucial for that purpose, somewhere about the posterior superior angle of the left parietal bone. The cranial cavity having been opened the dura mater was found separated from the bone by a layer of blood clot, extending for a considerable distance around, especially towards the wound caused by fall. The clot for some distance was removed after enlarging the bone aperture by means of Hoffmann's cutting forceps, no bleeding vessel was observed and there was no bulging of the dura mater. The cerebral

pulsations were quite distinct. After the operation which was performed under the influence of chloroform, the pupils were minutely contracted and equal, due probably to the anæsthetic. Pulse, 92; breathing, 20 per minute. The scalp was replaced over opening and the whole covered with a large fold of oiled lint.

March 15th (3 a.m.), sleeping. 10 a.m., still in same condition. There has been no further twitching, and he moves right limbs equally as well as he does left. Pupils normal. He puts out his tongue when asked to do so. No vomiting, pulse, 88; temperature, 99. From this time the patient went on uninterruptedly well. On March 16th, the second day after the operation, his intellect was practically clear, and there were no evidence whatever of any paralysis. Two small surfaces of bone became exposed in wound (which was at first poulticed and afterwards dressed with carbolic oil), but soon became covered with granulations. The temperature never rose above 99°, and there was nothing more than slight superficial suppuration about wound at any time. On March 27th, he was allowed to have a little bread in addition to the milk which he had been having alone, and on April 10th, was allowed to get up in the evening for a short time. The wound had almost entirely healed on April 19th, but the pulsations of brain were clearly visible in the depression left.

The patient is still in the hospital but quite convalescent.

Remarks.—Of the main points of interest about the case probably the two most worthy of remark are first, the comparatively indefinite and obscure nature of the symptoms and their causation; and secondly, the indications for the treatment which was followed by such marked success.

The condition of the boy when brought in on March the 9th, appears certainly not more dangerous than that of many patients suffering from scalp wound with some small amount of concussion; and had it not been for the question of fissure of the bone, raised by the examination of the wound, I doubt whether it would have been deemed necessary to admit him into the hospital.

Whether there really was a fissure of the cranium or the appearances were due, as Mr. GOLDING-BIRD suggests, to turning up of the pericranium it is impossible to say, but certainly the symptoms which followed might be readily explained on the supposition that such was the case; namely, that the patient had sustained a fissure of the bone, which was giving rise to a slow or passive intra-cranial hæmorrhage, followed at first by symptoms of cerebral or surface irritation, and terminating in hemiplegia with twitchings.

This explanation was verified to some extent by the conditions found on opening the skull, for the clot was seen then to extend undiminished in the recess, for some distance in the direction of, if not actually to, the site of the primary wound. Of course all the symptoms could as readily be explained by concussion of the head leading to tearing of some small vessel or vessels passing between the dura mater and the bone, or to rupture of a sinus in the neighbourhood. Whether or not there was a fissure, the case was evidently one of cerebral irritation accompanied by slow intra-cranial hæmorrhage.

The elevation of temperature, though not great, might suggest the possibility of meningitis, and subsequent intra-cranial supporation, but the absence of rigors and other signs of constitutional disturbance, together with the short duration of the case (intra-cranial suppuration rarely takes place before the 7th or 8th day after injury), rendered their presence highly improbable.

It is worthy of remark that though the symptoms were entirely relieved by the operation, the whole of the clot was not removed, the remainder, probably through exposure to air, breaking down and coming away as with other discharge from the wound.

As to the indications for the treatment pursued, little need be said beyond that the patient's condition was one of extreme gravity and having a history of local injury with subsequent swelling, though not of an inflammatory nature, it seemed advisable to give him the chance which the operation of trephining alone could offer.

The operation of trephining for intra-cranial hæmorrhage due to injury, is not one of the most successful by any means of surgical operations owing in a great measure to uncertainty in diagnosing the exact locality of the lesion, and also to the desperate conditions under which the operation is usually performed.

ERICHSEN says, that during 25 years at University College, only 3 cases have required the operation, two of which proved fatal.

Dr. GROSS gives 12 cases of trephining for intra-cranial hæmorrhage from various vessels six of which were unsuccessful.

A. G. BARRS.

NOTES OF THE MONTH.

ADDITIONS TO THE MUSUEM BUILDINGS.—The excavations that have been going on for the last fortnight in front of Bett's museum, are for the reception of a new block of buildings in connection with the school. In the first place, what has hitherto been known as the Practical Physiology Room, is to be pulled down, and the ground it covered will be thrown into the "Park," and the new wing will be brought forward level with end of the dissecting room as it now is. Going into details the additions will consist of five new rooms distinguished in the following way. On the *ground floor* two rooms, each 37 feet long, 21 broad, and 15 high, and separated by a passage leading to the vestibule in front of the anatomical theatre, the room on the right will be lighted by five large windows, two facing the Park and three facing Hunt's house. The *first floor*, will consist of three rooms, each 15 feet high, one very large, one nearly 50 feet long and 21 broad, and lighted

from above by two skylights, in shape like the section of a decagon, the remaining two smaller rooms will also be provided with a similar skylight each. Ascent will be made to the first floor by a staircase which is to occupy the place of the little ante-room, which now contains the collection of skulls, the vestibule will thus be much enlarged. In the basement on the left there will be a slight continuation of the "Catacombs," and all this underground system is to be ventilated by an air shaft supplied with gas burners, all the effluvium will thus be effectually disposed of. The whole block will have a front elevation of 30 feet; the pediment and cornices will be of Portland stone, and the facade being supported by Corinthian and Doric columns, the addition will be handsome as well as useful. The whole structure is to be fire-proof, and the present system of hot air pipes will be continued into the various rooms. It is not yet specified to what uses the different rooms will be put, but we understand that the large room on the first floor is to be the practical physiology room.

NEW ENTRANCE SCHOLARSHIPS.—We have received a notice of the new scholarships to be competed for in September next. They are two in number, of the value of £100, and tenable for one year. The Subjects of the examination for the one in Science are:

1. Physics.
2. Inorganic Chemistry.
3. Botany.
4. Zoology.

The Subjects for the other called "Open Scholarship in the Subjects of Preliminary Education," are:

Latin.
Euclid, Algebra and Arithmetic.
French.
Greek or German.

The examination commences on Tuesday, September 25th. This is a step in the right direction, and will tend to place us in the front rank with the other great schools as far as regards entrance scholarships, it remains to be seen what it will do towards increasing the entry of new men. At any rate it will bring good men together for competition, and we shall gain in that respect. After the vast amount of talk there has been lately about science in medicine it will be interesting to see the respective numbers for the above competition, and also to know their relative value.

ELECTIONS TO THE STAFF.—We have great pleasure in recording the election of Mr. John Birkett, F.R.C.S., and Vice Pres., R.C.S., as consulting surgeon to this hospital. Many of us can remember the crowd that attended his last lecture on Surgery in the Anatomical Theatre, and sorry we were to lose him; now he has received the highest surgical honours that this hospital can give, and we hope we shall not altogether lose sight of him here, for although one of our consulting surgeons is to be seen usually once a week in the theatre, the other is quite unknown to the majority of the students.

It is with still greater pleasure that we notice also the recent election of Dr. Goodhart, to the post of Assistant-Physician at this hospital. Any one who has been Medical Ward Clerk under him, or who has attended his demonstrations in the post-mortem room, cannot but be glad at such a well-merited honour. Dr. Goodhart took the highest place in honours for his degree in the University of Aberdeen, and is chiefly known in connection with Pathology.

PRESENTATIONS AT THE UNIVERSITY OF LONDON.—On May 9th, the following Guy's men were presented:—

For the degree of M.B.—Mr. W. A. Kidd, Mr. Lamb, Mr. A. H. Jones.

For the degree of B.S.—Mr. W. A. Kidd.

For Gold Medal in Forensic Medicine.—Mr. W. A. Kidd.

For Gold Medal in Organic Chemistry and Materia Medica at 1st M. B. examination.—Mr. J. E. Uhthoff.

"ECONOMY" IN THE WARDS.— Some strong enactments limiting the power of Dressers, Clinical Assistants, &c., in the matter of precription and necessary comforts for patients in the wards, have just been issued; we feel the subject to be of such importance that we reserve further examination of it till our *June* number.

Correspondence.

TO THE EDITOR.

SIR

The following case of abnormal appetite is interesting to me, for I never met with anything of the sort before.

A child, just upon 3 years old, pulled a kettle of boiling water over herself scalding her arms and legs. I was called to attend her.

The mother drew my attention to the fact that, when the child was able to get about, it amused itself nearly the whole day long, every day and always, in eating chalk and the plaster which it picked from the walls of the cottage. I was shown large "tracts," each bigger than a man's hand, where the paper had been torn off by the child and the plaster and mortar eaten. The mother told me that the little girl frequently ate lumps of chalk as large as an ordinary size tea-cup in the course of the day. Sometimes the child has been shut up or kept under careful observation to prevent its getting at the chalk, with which this place (Brighton) abounds, and then the child has always fretted and wasted and refused its proper food. If offered cake, sweets, or chalk, it always chooses the last; it does not care for the first two mentioned things, in fact, at all. Since the child has been under my observation, I have sometimes given it a teaspoonful of the Pulv. Cretœ Prep. of the B.P., and have sometimes with-held it, under which latter circumstances the girl has not done so well, but has "pined," refused its food and fretted.

She is well nourished, and, when able to get at the chalk and mortar, is healthy and contented. She has never had worms.

Will you or some of your readers kindly tell me if I can find any similar cases recorded, and if so, where; also if it is wrong to allow the child to follow its peculiar inclinations, and what the cause of so strange a fancy can be.

I am, SIR,

Your obedient Servant,

JUVENIS.

ON THE ADMINISTRATION OF ANÆSTHETICS.

TO THE EDITOR.

SIR,

Within the last three years, fatal cases have occurred during the "process" of anæsthesia, under the exhibition, of nitrous oxide gas, chloroform and ether.

The chloroform cases are sufficiently known to the profession, and have unfortunately been too often laid before the public.

A death during the administration of pure ether, which happened at one of our London Hospitals, has been wisely kept from the public, and I am now only allowed to mention it through the kindness of the surgeon by whom resuscitation was attempted.

But now general attention is drawn by a recent sad occurrence in Manchester, and after a personal interview with the operator in that distressing case in which a much respected surgeon (a Guy's man) lost his life, I can come to no other conclusion but that the gas was the only cause of death. It is well known to those who often administer the gas that unpleasant effects may follow its inhalation, so that the administration of nitrous oxide, and of anæsthetics generally, take rank amongst the medical procedures which endanger life, and require skill for their right conduct.

The law does not allow an unqualified man to practice medicine or surgery, yet under whatever category the administrator of anæsthetics may fall, unqualified dentists are permitted to administer gas themselves and extract, thus actually practising a critical medical act before their patients. Surely here is a great anomaly.

It is not a common thing for unqualified persons to administer anæsthetics in private practice, yet it is only of late years that experienced men have been called into requisition, and though often perhaps the surgeon's own experience would justify his using the anæsthetic, it should be remembered the surgeon is fully occupied with the work immediately under his fingers, which work is often far from the seat of administration of the anæsthetic, so that the life of the patient is directly in the hands of the administrator of the anæsthetic.

A sincere friend of mine of large operating practice, where the administration of the anæsthetic is immediately under his own eyes (and nose) when operating, assures me that he would much prefer the responsibility for the safe adminstration of the anæsthetic be taken off his shoulders.

Surely there are ethies in the practice of anæsthetia, and it is with the object of establishing these that the foregoing observations are submitted for ventilation to such a worthy school.

Yours very respectfully,

38, Brook Street. TOM BIRD.

EXAMINATION NEWS.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

EXAMINATION FOR THE LICENSE (SECOND PART, OR PASS). APRIL, 1877.

MIDWIFERY AND DISEASES OF WOMEN.

1.—What are the signs and symptoms of effusion of blood in the immediate vicinity of the uterus? Mention the various causes of such hæmorrhage.

2.—Describe the conditions under which albuminuria is observed in connection with pregnancy and childbed; set forth the pathological events that have been observed in this association; and state how you would act with the view of averting those events, or of treating them when they appear.

3.—Give the measurements of the average sized fœtal head at term, and describe the alterations in these measurements which occur, or may occur, during parturition.

4.—Enumerate the various tumours that may obstruct labour; state how you would diagnose obstruction to labour from this cause; and how you would meet the difficulties arising from it.

5.—What is meant by the term "transverse presentation?" Point out (*a*) the dangers and difficulties attendant on cases of this kind, and describe (*b*) the appropriate treatment.

MEDICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF MEDICINE,

INCLUDING THE PRINCIPLES OF PUBLIC HEALTH.

1.—A man of middle age, and somewhat anæmic, but of fair general health, is liable to epileptiform attacks, beginning in the right forearm. He has dropping of the left upper eyelid and dilatation of the left pupil. What is the probable nature and what the probable seat of the malady? In what manner would you treat the case?

2.—Describe the symptoms of Pyæmia; mention the diseases for which it may be mistaken; state the means of discriminating between them, and set forth the general rules which should regulate the management of "pyæmic" affections.

3.—Describe the appearances presented by the expectorated matters in diseases of the lungs; state the causes of the respective differences in these substances and their diagnostic value.

4.—State the circumstances which would induce you to tap, and those which would induce you to refrain from tapping in a case of pleuritic effusion.

5.—Give the clinical history of a case of enteric fever and state the diseases for which it may be taken.

6.—A town being threatened by an invasion of epidemic disease, what instructions would you issue, if required, for its prevention?

MATERIA MEDICA, AND CHEMISTRY IN ITS APPLICATIONS TO PATHOLOGY, PHARMACY, AND TOXICOLOGY.

1.—Describe the physiological and therapeutic uses of—
1.—Sulphur. 2.—Iodide of Potassium. 3.—Cod Liver Oil.

2.—Give an account of "*Spasmodics*" (remedies which excite muscular contraction) and "*Antispasmodics*" (those which relax muscular contraction), and indicate their uses in disease and in controlling each other's action.

3.—What weight of Carbonic Acid Gas can be obtained from 1 oz. of pure dry Carbonate of Soda, and how much pure Oil of Vitriol would this amount neutralise?

4.—How is Ether prepared? Explain the chemical changes which occur in the ordinary process for its preparation.

5.—Explain the preparation and composition of diluted Hydrocyanic Acid. State by what chemical antidotes it may be converted into an innocuous substance.

6.—State concisely what you know respecting the Chemistry of the Blood, more especially as regards its composition and the changes it undergoes during Arterialization.

GUY'S HOSPITAL.—MICHAEL HARRIS PRIZE.

THURSDAY, MARCH 22, 1877. (10—1.)

1.—Describe the Cuboid Bone.

2.—The skin is reflected from the front of the arm over a space bounded by (1) a line connecting the two condyles; (2) a transverse line two inches higher up the arm and parallel to the above; (3) the dissection to be carried down to the bone, and to be limited on either side by the intermuscular septa. Describe all the structures seen in this space, except the bone.

3.—Describe the structure of voluntary muscle, and state in what particulars the muscle of the heart differs from the above.

4.—In what way is blood supplied to, and returned from, the muscular structure of the heart *itself?* Describe the arrangement of the cardiac vessels.

5.—State the nature of the epithelium in (*a*) the uterus, (*b*) the vas deferens, (*c*) the ducts of the nipple, (*d*) the different parts of the nesal fossa, (*e*) on the front of the epiglottis, (*f*) in the true vocal cord.

6.—Describe the cervical plexus of nerves, mentioning how it is formed, its position and its branches of connection and distribution.

FRIDAY, MARCH 23, 1877. (10—1.)

2.—Name in the order of their position all the muscles which are attached to the radius. Give also their nerve-supply.

2.—Describe the nesal fossa, mentioning the bones which form their walls, the openings by which they communicate with other cavaties, and the arteries and nerves distributed to their lining membrane.

3.—A needle is thrust into the cavity of the abdomen at a point seven inches to the side of the umbilicus. Enumerate in their order the structures of the abdominal wall which it will pierce, and give all the attachments of each of the muscles.

4.—Describe the means by which the spinal cord and its membranes are connected with the walls of the spinal canal and each other.

5.—Enumerate and describe the anastomoses by which the circulation would be maintained if the Common Femoral Artery were ligatured before it had given off any branches.

6.—Give the dissection by which you would expose to view the course of the Right Recurrent Laryneal Nerve, from its origin to the lower border of the Cricoid Cartilage. Mention in order all the structures which you would have to divide or turn aside. Give the communications and distribution of the whole Nerve.

L.R.C.P. PASS EXAMINATION, April.—The following Guys' men went up and all passed:—Messrs. W. P. Reynolds, Pickering, Cusack, and Lee.

COLLEGE OF SURGEONS PRIMARY.—The men composing the first "batch" all passed:—Messrs. T. J. Morrison, H. Austen, R. Pemberton, A. L. Smith, Edwin O. Jago, H. E. Wright, James T. Bishop, F. T. Jones, L. C. Woolridge, W. H. White, H. E. Flanagan, W. Crew.

COLLEGE OF SURGEON'S PRIMARY.—Second Batch. All Guy's men passed:—Messrs. A. K. Morgan, R. T. Bedford, P. Gt. G. Williams, L. P. Morgan, G. Steele Perkins, J. T. Brett, A. H. Pierson, W. Whitworth, P. M. Wood, B. N. Rake, H. A. Clowes, J. S. Crook.

UNIVERSITY OF EDINBURGH, 1st M.B.—The following Guy's men went up and all passed.—Messrs. Hobson, J. Sykes, J. F. Tabb, Stanford Magrath, and W. Clement Milnard.

Errata in April number of *Gazette*.—The Michael Harris Prize is for *Anatomy* alone, and not for Anatomy and Physiology as was stated. P. 40, line 21 from top *for* "being we thought" *read* "though rare is."

STATISTICAL REPORT OF LYING-IN CHARITY FOR MARCH, 1877.

Number of women attended		214
Recovered	212	
Died	2	
	195	
Single Births	211	
Dual	3	
	214	
Women attended in 1st confinement	31	
" " 2nd "	26	
" " 3rd "	29	
" " 4th "	25	
" " 5th "	23	
" " 6th "	25	
" " 7th "	21	
" " 8th "	11	
" " 9th "	11	
" " 10th "	6	
" " 11th "	1	
" " 12th "	2	
" " 13th "	1	
" " 14th "	1	
" " 20th "	1	
	214	

Children at full time.			
Males alive	109		
Males dead	2		210
Females alive	95		
Females dead	4		
Permature children.			
Males alive	1		
" dead	2		5
Females alive	0		
" dead	2		
Abortion			2
Total number of children			217
Alive	205		217
Dead	12		
Presentations.			
Vertex		206	
Breech		4	
Feet		3	
Vertex and hand		2	
Both Hands		1	
Abortion		1	
		217	
Operations.			
Forceps	4		
Perforation of distended abdomen	1		
	5		
Externs attended.			
Mr. J. Poland			42
Mr. J. Russell Harris			42
Mr. J. Steele Sheldon			24
Mr. J. C. Uhthoff			41
Mr. T. Hammond			29
Mr. M. F. Cock			36
			214

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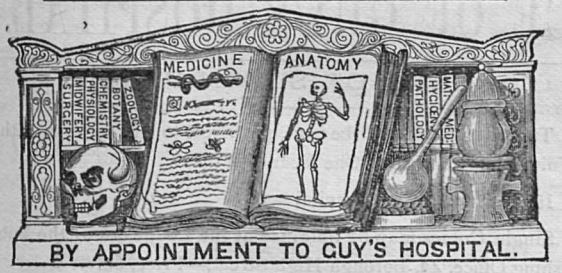

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Charing Cross ...	1 p.m.	1 p.m.	Tu. F. 1.30	...	M.W.F., 9
Guy's	1.30 p.m.	1.30 p.m.	M. W. F. 1.30,	M.Th. 1.30 Tu. F., 12.	Tu. Th. F. 12
King's College ...	2 p.m.	1.30 p.m.	M. W. F., 1 p.m.	M.Th.,S. 1	Tu. F., 10
London	1.30 and 2 p.m.	1.30 and 2 p.m.	...	W. S., 9	Tu., 9
Middlesex	1.30 p.m.	1 p.m.	M.W., 1.30	Tu.F., 8.30	Daily, 9
St. Bartholomew's	1.30 p.m.	1.30 p.m.	M. Th., 2 W. S., 9.	Tu.Th.S., 1.30.	Fr., 9
St. George's... ...	1 p.m.	1 p.m.	Th., 2.	W. S., 2	Tu.S., 9.30 Th., 1.30
St. Mary's	1.15 p.m.	1.15 p.m.	Fu.F., 9.30	M.Th. 1.30	W. S., 9.30
St. Thomas's ...	8.45 a.m.	8 a.m.	W.F. 12.30	Daily, 2, ex. S.	Tu. F., 10
University College	1.15 and 2.30 p.m.	1.30 and 2 p.m.	Daily, 1.30 ex. W. & S.	M. W.F., 2	W., 10.30
Westminster ...	1.30 p.m.	1.30 p.m.	Tu. F., 3.	M. Th., 3	W. S., 9·15

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All communications for insertion should be addressed to the Editor.

Country Subscriptions, Advertisements, and Business Communications, must be sent to C. K. SHAW, Esq., Guy's Hospital, to whom Post Office Orders, should be made payable at the Post Office, Borough High Street, S.E.

Clinical Surgery.

MR. DAVIES-COLLEY commenced his lecture by remarking that the cases best suited for cliniques, might be divided into two classes, viz.,

1.—Rare affections, and those that require peculiar treatment.

2.—Common diseases presenting difficulties in diagnosis and treatment.

As an example of the first class, the lecturer brought forward the case of a man, æt. 30, a tea-planter in Assam, who accidently shot himself, the bullet passing in beneath the lower jaw made its exit about one inch below the eye on the opposite side, completely smashing the superior maxilla. For the first 7 weeks after the accident, the patient received no treatment whatever, but he afterwards had several operations in Calcutta, the nature of which, however, cannot be made out.

The lower jaw has united, but the central incision on the right side, and all the teeth on the left side anterior to the molars, with the corresponding portion of the alveolus is wanting. The greater part of the left upper jaw with the antrum, is also wanting, the turbinated bones being exposed, the left cheek is much fallen in, and represented only by a depressed cicatrix, by which the angle is drawn up to about an inch above the right angle showing the teeth: owing to this together with loss of the right side of the lower lip, the saliva is continually escaping. The left side of the tongue is attached at a point about half an inch below the first molar; this, the patient says, has been separated several times, but has always again united.

In treating this case there are *three* points to remedy, viz.,

1.—The overflow of saliva.

2.—The speech; the patient being prevented talking by (*a*) the absence of hard palate on one side, (*b*) the tying down of the tongue.

3.—Disfigurement.

In order to correct the above, MR. DAVIES-COLLEY proposed to free the lip by making an incision downwards, on either side of the V shaped opening (where the lower lip is wanting), at a short distance from its margin, and from the lower extremity of this incision, to cut obliquely down and outwards below the chin, then to unite these flaps with hair lip pins in the mediam line, and allow the chin to fall and unite to the lower borders of the flaps. As many operations have already been performed, there is a probability of the skin not stretching, in which case a lower lip would be cut from the right cheek and turned down. To free the tongue is easy, but owing to want of extension it would probably unite as before; MR. DAVIES-COLLEY therefore proposes to remove as much mucous membrane as possible with the tongue from the jaw, then by sewing the edges (of the m. m.) together under the tongue, hopes for primary union and so the prevention of re-adhesion. The palate, of course, to be remedied by an artificial one.

As examples of the second class, MR. DAVIES-COLLEY brought forward two cases of Hip-joint disease, both of which had been under his care a long time.

The one, a girl, æt. 9, admitted February 16th, 1876. She had been ill since Whitsuntide, 1875, had attended at out-patients, and had weights applied.

On May 24th, 1876, the head of the femur was resected, and was found caseous and eroded. Patient did well at first, but afterwards the discharges increased and she got thinner, so in February 1877, was again operated on, no dead bone was found, but an abscess near the joint which was opened and the sinuses slit up, since this she has greatly improved.

The other, a boy æt. 17, admitted 27th November, 1876. On December 8th, under chloroform, the thigh was found abducted 60° from the vertical, the adhesions were broken down and a splint applied; at the end of January he got up with limited movement in the joint.

Feb. 2, a fluctuating swelling was found in the groin, which was aspirated on March 13, and on——April incisions were made both anteriorly and posteriorly (antiseptically), he had, however, got worse, and now that there is fluctuating behind the trochanter MR. DAVIES-COLLEY proposes making a bold incision, and will then, probably, re-sect the head of the bone.

1.—*Age.*—Both cases young. Hip-joint disease usually occurs in patients under puberty, and in this respect differs from other diseases of joints: *e.g.*, knee and elbow. Of course osteo arthritis is excepted, the symptoms of which cannot be confounded with ordinary Hip-joint disease.

2.—*Family History.*—Good. It usually is good; therefore make use of local measures and not constitutional treatment.

3.—*Cause.*—In the one, cold; in the other, negative. The causes of this disease are generally slight injury to bone, or ligaments; *e.g.*, slight twist, rupturing some fibres of the ligamentum teres: no reason is in many cases assigned because the slight character of the injury is forgotten, if it were a more severe injury it would be treated at once.

The division of joint diseases as usually made is into those commencing as

1.—Inflammation of synovial membrane, spreading towards the bones.

2.—Disease of the ends of bones, or articular ostitis.

The disease is generally articular ostitis, rather than synovitis, and if we could diagnose this, we should re-sect at once. If the bone is uniformly eroded, the disease began as synovitis; but if a sequestrum be found we may say it began in the bone.

MR. DAVIES-COLLEY divides the symptoms of Hip Joint disease into those of *two* stages; viz., the early

and the late. The symptoms of the early stage are 1.—*Pain*, both in Hip and knee, due to the obturator nerve supplying the ligamentum teres (where the disease frequently begins), and in the side of the knee with a *limp* in walking.

2.—*Deformity.*

(*a*) Apparent lengthening, we find this associated with *ab*duction, semiflexion, and *e*version. (If there really is any lengthening it may be explained by effusion between the head of the bone and the acetabulum).

(*b*) Apparent shortening, we get *ad*duction, semiflexion, and either *e*version or *in*version. *Note*, if on the dead subject a hole be made into the acetabulum and fluid injected we get position (*a*) due to distension of the joint; this is an earlier stage of disease than (*b*).

(*c*) Flat buttock, partially due to position of the limb but chiefly to the wasting of the glutei muscles.

(*d*) Lordosis; in order to walk, the thigh must be put down vertically, but as the thigh will not flex, the pelvis becomes bent forward and the back curves in.

(*e*) Wasting of muscles; in cases where the supposed disease has gone on for one year without any wasting, we may say it is hysterical and not true hip joint disease.

3—*Spasm*, impaired movement. We can rely most of all on the movement, with the thigh, of the anterior superior spine of the Ilium. The muscles contract in order to keep the joint quiet, when in sleep these relax, there is movement in the joint giving pain, and consequently the screaming and starting up at night so characteristic of this disease.

4.—*Pain on Articular Pressure.*

In the late stage

1.—All the above symptoms are aggravated.

2.—Sinuses or abscesses form.

3.—Real shortening; a portion of the acetabulum wastes, therefore we may get an appearance of disease before it has really taken place; sometimes dislocation.

4.—Hectic; the result of prolonged suppuration.

The position of abscess is generally in front of the great trochanter; being, in the above cases, in front of the hip joint, it is probable the disease began in the acetabulum;—some abscesses point in the gluteal region, &c. &c.

Treatment. In the early stage, rest with extension by weights and splint. In the late stage, rest, unless the patient goes down, in which case operate.

Resection, this operation ought to be performed (*a*) when yon know the disease has reached the 2nd stage and the limb is in bad condition.

(*b*) In the 2nd stage when the patient is suffering from excessive discharges, &c., its advantages are, that you (*a*) remove carious bone, either from the acetabulum, or head of the femur, and (*b*) give a free opening for pus. Its results are better than where nature has cured the disease, because we obtain more movement: It is a safe operation in children. Its dangers, as before the operation, the patient is liable to lardaceous viscera from continual suppuration; more so in this than in any other surgical affection.

[Since writing the above Mr. DAVIES-COLLEY has operated on the first mentioned case in the manner already described. The operation took place on the morning of the 19th inst., ½ grain of morphia given about 1·15, soon after 3·30 p.m., the patient became insensible and stertorous with pupil contracted he was galvanized, had ammonia and brandy enemata and came to between 9 and 10 p.m.—H. L. M.]

Clinical Medicine.

The following case, recently in Stephen Ward under Dr. Wilks, may be of interest to many readers of the *Guy's Hospital Gazette*, as showing some of the difficulties of Diagnosis between Typhoid Fever and Tuberculosis. We are all aware of the importance of forming a correct Prognosis; its difficulty is well shown by the present case, a study of which may however help to render this difficulty less hereafter. The prognosis of Fever in a healthy boy would be favourable; of Tuberculosis, decidely unfavourable.

Another lesson to be learnt is, that in all doubtful cases the Opthalmoscope should be used, had this not been overlooked in the present instance we may safely say that an accurate diagnosis would have been formed and the lad condemned at once, or rather, as Dr. Wilks remarks, a "Diagnosis" would then not have been necessary, any more than one diagnosed broken leg, when one sees the ends of broken bone protruding through the skin,—but tubercles would have been distinctly *seen*, so close were they to the optic disc.

W.N., æt. 14, a well nourished lad came among Dr. Pye Smith's out-patients with moderate fever, and slight pain in right iliac region, and was admitted April 11th, 1877, as a probable case of Typhoid Fever.

Occupation, a Locksmith's apprentice.

Family History, Negative.

Personal, Never strong. Three weeks before admission had pains in the head, but did not have any sickness until a fortnight afterwards, when he also complained of feverishness at night. Has not had any Diarrhœa. During these three weeks he had a slight cough, but did not expectorate.

On admission. Cheeks flushed, and general feverish appearance, complains of *slight* pain in the Right Iliac Region; tenderness in the Left Iliac Region, and over Liver and Spleen on percussion.

Heart, Normal.

Chest, Expands equally, a Rhonchus is audible now and again at right apex. Behind, dulness extends as high as the lower angle of the Scapula on both sides; Rhonchi at right base.

Abdomen, rather full, but no spots.

Urine, Normal

Tongue, Whitish fur.

Bowels, constipated, the *Fæces* dark in colour.

April 12th, Temperature 102·2°, ordered Mist, Quinine ʒj. t.d.s. *Diet*, Milk and Farinacea.

April 14th, Crepitation distinct at Right base. Temperature, Morning 103·6°; Pulse, 108; Respiration 21. Evening, 104·2° ; Pulse, 120 ; Respiration, 26.

April 16th. Two or three small spots, vesicular in character, over Left Hypochondriac Region, but more numerous over the loins. After this day, the Temperature varied between 101°—twice only, being below—and 103°. It reached 104° on the morning of May 1st, 103·8° in the evening, and falling to 100·2° the next evening. The evening temperature was with two or three exceptions lower than the morning, sometimes as much as 2°.

On the 27th April, when taken nine times, it varied from 101·2 at 10·30 a.m. to 102·2° at 9·30 p.m. the highest being, reached at 3·30 p.m. viz., 104·6.

On the 5th May it rose from 102·2° Morning, to 104·4° Evening, the next night reaching 105.4°, and falling to 103° the night of his death. (May 7th.)

The respirations steadily increased from 21 on the 13th April to 40 on the 26th, after this date they were never lower, generally averaging 46, and on three occasions reaching 50.

The pulse also increased from 108 to 150.

The Bowels rarely moved more than once, and sometimes not at all in the 24 hours, the motions always being formed and generally dark in colour.

April 20, Sputa very viscid and rusty coloured.

April 21st, a decided change in his appearance, his face ashy pale, and himself says he feels worse.

April 23rd, still crepitation on right side; tongue furred.

April 25th, some Epistaxis; Sibilant Rhonchi on both sides in front, moist sounds on both sides behind, Sordes on teeth and lips; appears a *little* deaf.

April 28th, more Epistaxis; Râles at bases; Pulse weak and fluttering.

April 30th, tongue cracked and furred, much muscular tremour, a little delirious last night.

May 2nd, noisy delirium, sick after taking food.

May 3rd, cough very troublesome, ordered Decoct Senegæ. Mist. Ammoniæ, aa. ʒ ij. Secunda quaque horas. Brandy ʒ vi.

May 6th, Râles over both sides of chest, especially in front, have considerably increased during the last few days.

May 7th, still delirious, but at times recognises his friends. Pulse, so quick and feeble that it was impossible to count it. Patient died soon after midnight.

Autopsy, made 25 hours after death.

Brain, 46 ozs. apparently healthy; the membranes perfectly normal.

Heart, 7 ozs., healthy.

Lungs, crowded with tubercle; the miliary bodies being opaque, larger and more numerous at the apices, and the left apex somewhat the more infiltrated.

Glands, at the root of the Lung were distinctly tubercular, no evidence of old caseation. Small tubercles studded the Peritoneal covering of the liver, and many were found in that viscus.

Spleen, 8 ozs., full of tubercles, some beginning to be yellow and opaque, but not confluent or softening.

Kidneys, 9 ozs., in these viscera tubercles were found not only in the cortex, but also radiating from the bases of the pyramids to the medulla in confluent groups, some of which looked ready to soften and form a vomica. There were a few caseating follicles in Peyer's patches.

On opening the eyes, there were found in one choroid, *three* tubercles each about the size of a pin's head; on the other side, there was one larger and two smaller. They were all on the side of the yellow spot and close to the optic disc. On stripping off the choroid they were found to be attached to that coat alone. They were sought in the cancellous tissue of both Sternum and Rib, but were not found.

Remarks, &c.

Dr. Pye Smith commenced his Clinical Lecture on May, 9th 1877, by speaking of the causes of Pyrexia generally, *i.e.*, of the Febrile state shown by the well known conditions of the tongue, the stomach, the circulation, urine, nervous system and temperature.

Fever may be due to external causes, and is then either

1.—*Irritative*, due to wounds, or other causes of inflammation, *e.g.*, Dermatitis from exposure to the sun. In this case the Fever is of small intensity, except in children ; or

2.—*Infective*, or *Fever of suppuration* accompanying septic poisoning and single or multiple abscess, *e.g.*, Pyæmia.

When a patient comes before us with Pyrexia, we must first look for any external wound or service of suppuration. If we are able to set these aside, we must then examine the internal organs when we may find abscess (*e.g.*, a suppurating hydatid of the liver) or ulcerative endocarditis.

With inflammation of an internal organ without suppuration the symptomatic Fever is small, *e.g.*, fatal peritonitis may be seen with no rise of temperature.

The only important exception in adults is the lung, therefore examine for pneumonia.

In children (and sometimes in young women, for instance in a recent case in Miriam Ward) the temperature may rapidly rise to 103° and subside again, from gastric disturbance or without any ascertainable cause. These cases of febricula are distinguished by their short duration. In all cases of continued fever, (pyrexia more than 1 week) when no rash has appeared so that typhus, variola and other exanthems are excluded, when there is no injury, and no source of suppuration, external or internal, and when acute Pneumonia is absent, the diagnosis practically lies

between Enteric without a rash, and acute Tuberculosis, and since both these diseases are more common in the young, the case before us offers a good example of the difficulty. Dr. Pye Smith then quoted the above details, and remarked, that although it is true there was some dulness with crepitation at the right base, and evidence of bronchitis elsewhere, the characteristic signs and symptoms of true acute croupous lobar pneumonia were absent. The condition of the Lungs was probably that of bronchitis with severe hypostatic congestion, and this was proved after death. This condition would agree either with typhoid fever, or with acute tuberculosis.

In favour of Typhoid were the following symptoms:

1.—Tumidity of the abdomen,—fairly well marked in this case.

2.—Tenderness in the right iliac fossa.

3.—Epistaxis.

4.—Night delirium with quiet muttering and wandering in the day.

5.—General aspect, dull and listless, with dorsal decubitus.

6.—Slight and doubtful rash not seen by the physician, probably sudamina. The age was in favour of Enterica sine Exanthemata.

7.—Gradual onset, without previous illness.

8.—Length of survival.

Symptons in favour of tuberculosis:—

1.—The delicate well formed features of the patient.

2.—The bronchitis.

3.—The irregular temperature, often very high in the morning and low in the evening, sometimes normal.

Against Typhoid:—

1.—Normal stools.

2.—No regular evening rise of temperature.

3,—No rose rash.

4.—The respirations were quicker than they should be in Typhoid fever, but this would be explained by the presence of "Typhoid congestion of the Lungs."

Against Tuberculosis:—

1.—No family history of Tubucular disease.

2.—No previous phthisis.

3.—No orthopnœa.

4.—No Cyanosis (yet there certainly was blueness of the fingers latterly).

5.—Six weeks is long for acute tuberculosis, though not for typhoid.

We would mention that occasionally tuberculosis becomes chronic, then it commences as acute disease. A case in Stephen Ward now, admitted nearly 3 months ago, is that of a young man, who on admission had persistent elevation of temperature, with furred tongue anorexia, but *no rash*; similar, therefore, to the above case; at the time Dr. Wilks said it was either typhoid or tuberculosis. No physical signs could be detected, until at the end of six weeks or two months it was found that air certainly did not enter the right apex so well as the left. The patient is now walking about the ward.

It is worth remarking that there was no tubercle in the membranes of the brain, had there been, we should have seen coma supervene, and the case would have been more rapidly fatal.

We would urge in conclusion, that in those cases where, other conditions being excluded, a doubt remained between typhoid fever and tuberculosis, the Ophthalmoscope be used, for though we fear it has been, in similar cases at Guy's, *without* success, yet we feel sure that had it been used in this particular instance, the tubercles must have been seen, so large were they, and so close to the Optic Disc.

Since writing the above we find, in a lecture delivered by Dr. Hughlings Jackson, "On Ophthalmology in its relation to Medicine," published in the *Lancet* of May 12th, 1877, the following passage. We cannot do better than quote it.

"The Ophthalmoscope is valuable as revealing to us tissue changes, which are parts of, or local development of, general morbid states. We may see tubercle in the Choroid during acute Tuberculosis. The first case of this kind discovered in this country was by Sœlberg Wells. Such a discovery may be of great help to us towards the very difficult diagnosis of tubercular meningitis as it occurs in the adult."

APPOINTMENTS MADE AT THE MEETING OF THE MEDICAL COUNCIL, ON MAY 25TH, 1877.

Resident Obstetrics.—Lee (June), Judson (July), Barrs (August.)

Dressers.—Wainewright (Mr. Cooper-Forster), Paddison (Mr. Bryant), Birdwood, Chubb (Mr. Durham), Manby, Beale (Mr. Howse).

Eye Wards.—D. Malpas, G. A. Wright, W. C. James.

Medical Ward Clerks.—Flower, Berry, Granger, Hartley, Morley, J. Davies, J. Hart, W. Phillipps, G. H. Russell, J. R. Harris, Griffiths, Coles, Apthorpe, Keogh, R. Steele.

Obstetric Out-patients' Clerk.—Earle, D. Giles, E. Morse.

Assistant Surgeons' Dressers.—C. L. Jones, Elliot, G. West, Jones, Baldwin (Mr. Davies-Colley), Alexander, Fookes, Langley, James (Mr. Lucas), Hawkins, S. Theed, Cox, W. Leigh (Mr. Bird), Wilkinson, Pilkington, M. Cock, A. Burton (Mr. Jacobson).

Assistant Physicians' Clerks.—Monday, J. R. Harris, R. Ross. Tuesday, Briscoe, Walley (skin). Wednesday, W. A. Philipps. Friday, E. Bryden.

Dressers in the Surgery.—Peskett, Clowes, Sercombe, Fielding, J. S. Smith, Bothamly, Morse, P. Wood, Morrison, Austin, Wright, Flanagon, A. K. Morgan, Purson, Bedford, Stables.

Surgical Ward Clerks.—Haycroft, J. Reynolds, J. T. Brett, Rake, F. Jones, Sturge, P. Williams, Bryden, Hasper, Bayes, Morrison, Bishop, Bedford, Clowes, Crook, Sercombe, Jeyes, L. Borroughs.

Assistant Surgeons' Clerks.—C. Jago, Fox, Archer, Hearnden, Edwards, Luscombe, Broomfield, Pincott.

Aural Surgeons' Dressers.—Lowdell, F. C. Coley.

Electricity Clerk.—Briscoe.

Post-mortem Clerk.—Vacant.

Dental Surgeons' Dressers.—Vacant.

Externs.—C. Wood, A. Walker, H. Manby, C. Everest, S. R. Mathews.

Correspondence.

TO THE EDITOR.

SIR

The time has again come round when the different Hospitals in London will renew the old contest for the Shield, a trophy, I am sorry to say, not on the familiar walls of the Library, but adorning those of another hospital.

A Committee Meeting has been held and the Sports fixed for the 7th day of July, so that, if Guy's men set to work training at once, there is plenty of time to ensure success. We expect a more satisfactory meeting this year, and a day has been chosen which we hope will not clash with any other large attraction. It is hoped also that this year there will be no oversight in the matter of giving the Staff due notice, and forwarding tickets at the same time that subscriptions are invited. In choosing a local Secretary, it should be remembered that a good Secretary need not necessarily be a good athlete, and I think that to help him a Committee should be appointed consisting of two men of each year up to the fifth, to collect subscriptions as soon as possible; the work is more than one man can do.

I hear there are some promising freshmen at Guy's, and I hope they will stand us in good stead on the 7th.

Yours respectfully,

X.Y.Z.

TO THE EDITOR.

SIR,

In March last "One who has not been refused his appointments" raised a cry that has often been raised before that many men at Guy's are sent into practice without having had experience in "setting" those severer forms of fractures which necessitate the patients' confinement to the beds of the Hospital. As things exists, and we fear that they could not be altered, a great many men must go forth as Surgeons without having actually "set" a leg. But that some go out into the world without having seen a fracture set is entirely their own fault. After all, there is not so much to be done in "setting" a fracture. If one has seen several put up, it will be found comparatively easy to do it oneself, and with a fair amount of common sense the result ought to be good. To have assisted at "setting" a fracture of the leg is almost, if not quite, as good as having "set" it oneself, but we are sorry to say that many have not even done this. How is it? It has been suggested that two assistants should be appointed to each full dresser to help him in dressing his cases, and when it is his week of duty in setting his fractures. There are objections to this plan: thus, the full dresser's work varies so much that at times there would not be enough for his two assistants to do; and also that during his six months of office the dresser has, as a rule, has only two "take in weeks," so that the experience gained in three months assistantship—for six months would be too long—would be too little.

If men chose they could very easily see and assist in setting fractures.

The appointment of Surgical Ward Clerk lasts three months, and during that time there are three "takes in" for each Surgeon. The dressers have each a "take in" during that time, and as a rule are hard worked and glad of help. Now is the time to acquire that much sought after knowledge. In setting a fracture the dresser wants help, and he is obliged to obtain the aid of one of his fellow-dressers, often to that man's inconvenience. Why should not this help be rendered by the Ward Clerk? he would be giving assistance to one in need of it; and much more, he would be obtaining valuable practical experience. Much more so than pumping the sprays for the dressers of the Antiseptic Surgeons.

Every Guy's man has held the appointment of Surgical Ward Clerk before he is qualified, and consequently every man who leaves as a member of the Royal College of Surgeon's would have "gained experience in some of the most necessary items of the profession."

This month will see many new Ward Clerks commencing work, and we feel sure that if they ask their dressers to allow them to help in "setting" fractures, they will receive a ready acquiescence with their request.

Yours &c.,

K.

EXAMINATION NEWS.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

DIPLOMA OF MEMBER.

EXAMINATION ON SURGICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF SURGERY.

MAY, 18, 1877.

1.—Enumerate the Structures surrounding the Shoulder-Joint, and describe how they are affected in the different dislocations of the Head of the Humerus.

2.—If a ligature be placed around the Innominate Artery, by what vessels would the circulation be carried on in the Head, Neck, and right upper extremity?

3.—What is Lumbar Abscess? Describe the Pathological Changes in a fatal case, and in one which recovers.

4.—To what causes may Bubo in the Groin be attributed? and in what way does the treatment depend on the nature of the cause?

5.—Describe the treatment of Hydrocele in a Child, an Adult, and an old Man, and the reasons for the plan selected in each case.

6.—What are the common causes of Ectropion and Entropion? Describe the operations for their relief.

EXAMINATION ON THE PRINCIPLES AND PRACTICE OF MEDICINE.

MAY, 19, 1877.

1.—Give the Causes, Symptoms, and Treatment of simple Ulcer of the Stomach, and append two prescriptions suitable for an Adult suffering from the complaint, written out in full.

2.—Enumerate and describe the Morbid Conditions resulting from Chronic Lead Poisoning, and give the various modes by which Lead may be introduced into the system, with the appropriate treatment in each case.

3.—What are the Physiological and Therapeutic effects produced by Antimonial preparatious, Conium, Ipecacuanha, Elaterium, and Digitalis? Enumerate the Pharmacopœia preparations and average doses of the above remedies.

First Fellowship. May 25th, 1877.

Time allowed.—1·30 to 5·30. p.m.

1.—The Head being divided in the middle line, give, in their order, the parts found in dissecting from within, outwards to the surface, the region bounded by the horizontal plate of the Ethmoid and body of the Sphenoid above, the palate below, the posterior border of the right pterygoid plate behind, and the nasal duct in front.

2.—Describe the first four Cervical Nerves, giving the exact course, relations, and distribution of branches.

3.—What are the principal features which distinguish the skeleton of man from that of the higher apes?

4.—Describe the various changes through which the Male and Female generative organs pass in their transition from the rudimentary to the complete stage.

GUY'S HOSPITAL GAZETTE, *JUNE*, 1877.

SOME allusion was made in our last number to certain regulations, lately introduced with regard to the power of Dressers and Clinical assistants, to prescribe for their cases in the wards. The alterations amount to this,—that no Dresser or Clinical Assistant may prescribe anything whatever without at the same time obtaining the signature of the House-surgeon or House-physician; on the days of going round, however, any prescription that may be written on the bed-card is made up by the dispensers on the assumption that it has been directly ordered by the Surgeon or Physician. The Dressers in the Surgery, and the Assistant-surgeons Dressers at Out-patients have still their usual list allowed them, but Clinical Assistants and Dressers, with the exception of the Dresser for the week, who has charge of the surgery in the evening, have not that margin. We believe that these rules can scarcely be called new, for they were in force some twelve or fifteen years ago, the powers lately possessed by the holders of these two higher appointments must therefore be considered as privileges. But more than that, there can be no doubt that they increased the value of these appointments, especially in the case of the Clinical Assistants who now lose one of the main advantages over Medical Ward Clerks. As a matter of fact it has not been the custom for Clinical Assistants to commence the *systematic* treatment of new cases before the physician has seen the case, and in surgical cases that may happen to require special medical treatment, the Dresser waits for his Surgeon before commencing any particular line, except in an urgent case, when he consults the House-surgeon. It is important to remember all this because it has been alleged as a cause of much *waste* that the Dresser or Clinical orders medicine at 10 a.m., and his chief going round in the afternoon prescribes, with a disastrous effect on the first prescription. Any one who has held either of these appointments could give evidence that it is a comparatively rare thing for the Physician or Surgeon to have to annul a pre-existing prescription, except it be his own. It is also true, we believe, that some years ago it was found well nigh impossible to get any one to undertake the duties of House-surgeon, for he was then required, as he is now again, to supervise the Dressers, thereby getting into bad odour with the men, and having an alarming increase of work in addition. If the House-surgeon or House-physician means to do his work conscientiously he must inquire carefully into the circumstances before he signs any card brought to him, which amounts to his knowing every detail in the course and treatment of all the three hundred or so cases which he has undertaken to take charge of. If, on the other hand, he signs indiscriminately on the representation of the Dresser or Clinical, which he probably will have to do, in order to finish his wards in the course of the day, the signing tends to become a mere matter of form, and moreover the lamentable waste will still go on.

Facts are stubborn things, and a very stubborn fact is this one, namely—that the expenditure in drugs last year was enormous, far exceeding any previous year. Another fact may also be mentioned, that some sixty thousand out-patients are prescribed for every year, and about forty thousand of them by Assistant-surgeons' Dressers, while the number of surgical cases under treatment *in the wards* during the year, is usually about three thousand.

It is admitted by all that economy is a most important principle in one's education, and that we ought to learn it when we are young, hence we hope we are giving wise advice when we say to all our readers engaged in practical work in the wards "Be economical."

A LETTER from a correspondent in another column, warns us of the near approach of the Inter-Hospital annual contest at Lillie Bridge. At this athletic meeting, the struggle is for the possession of the handsome Challenge Shield which many of us can remember did *once* grace our library, but which now, alas, is not known to our junior men, at least in that recess over the fireplace. Certainly we are proud to see the Football Challenge Cup there for the second time, and it speaks well for the powers of Guy's men; it is the result of much hard work, and tells also of pluck and endurance. But we wish to impress it on those of our

readers that may be athletically inclined, that the presence of the Challenge Shield there, is far more important, and that there is plenty of room for it; they must not sit with their hands folded, and watch such a handsome trophy being taken triumphantly away to some other hospital. In June, 1872, it was secured for us chiefly through the exertions of Mr. George Power, and put in its place of honour in the library: the next summer, many of us can remember how it flashed and shone in the bright sun of the splendid day the united hospitals had that year for their champion meeting, but Bartholomew's simply walked away with it, and we were nowhere, with only one first and a few second prizes.

Last year it was certainly tantalising to be so very near, but we were only second; this year ought to see us *first*. But to obtain this result, we must work, and work hard, and now is the time. No elaborate system of training is necessary for this sort of competition, the most important item is perhaps regular exercise, once a day at least, and for long distances, early hours; for the short distances, a good start is indispensable, and nothing is easier to practice, yet many men have no idea how to start, and often lose a valuable yard or two at the commencement in consequence. Our jumping was good last year, we hope it will have the best of effects this year.

We hope the junior men will come well to the front at the trial heats, among so many there surely must be some serviceable men, and we are quite sure they will meet with every encouragement from the more senior men. The Guy's Athletic Club is in a flourishing condition, we believe, although no notice of a preliminary meeting has yet been posted up in the colonnade. There is no time to waste, and business arrangements should be commenced at once; the prizes given at the United Hospitals Meeting are always handsome, and we trust that this year the Committee will be able to keep up the reputation. Supscriptions will no doubt come in fast, for the cause is good, the development of nerve and muscle can go on perfectly well side by side with the development of brain tissue, and it is well known that many on the Staff of London Hospitals now, were once famous in athletics; at any rate it is very encouraging to us to see so many of our surgeons and physicians present at Lillie Bridge year after year.

NOTES OF THE MONTH.

COLLEGE OF SURGEONS, PASS EXAMINATION, May, 1877. Membership.—The following Guy's men passed:—J. C. Wilkinson, P. F. Gilbert, A. Stevens, W. Ekens, P. O. Haynes, Messrs. Baker and Womersley also passed in Surgery.

COLLEGE OF SURGEONS PRIMARY, Third batch, May, 1877.—The following Guy's men were successful:—Messrs. Henry H. Sturge, Edward Fielding, G. W. Flower, R. E. Morse, Francis A. Knipe, Charles J. Harper, John G. Barnes, Thomas B. Cross, H. W. Gosse, Thomas A. J. Howell, Frederick Combe, Sydney R. Matthews, Charles H. Downes, Alfred Scott, Edward S. Cockell, James J. Reynolds, Frederick T. Bayes, William P. Bothamley, Evan N. Davies, John Cock, Richard Steele, Thomas H. Morse, F. B. Bayer, F. J. Elliot, Josiah E. Viney, Charles Crossley, A. P. Lungley, James S. Smith, W. H. Sercombe.

COLLEGE OF SURGEONS.—FIRST FELLOWSHIP. May Examination.—Messrs. J. E. Morley, and T. W. O. Hearnden, from Guy's passed.

MICROSCOPIC CHARACTERS OF THE BLOOD IN PERNICIOUS ANÆMIA.—Messrs. G. MACKERN and H. DAVY, made some observations on the blood of a man, who was admitted into Philip, under Dr. MOXON in September last, with well marked symptoms of Idiopathic (Pernicious) Anæmia; the man died on November 24th, and the post-mortem examination confirmed the diagnosis, as no lesion was discoverable. Many microscopic examinations of the blood were made, and under varying conditions, when the temperature was 101° and when it was normal, when the man appeared to rally and when he became very low, but precisely identical results were obtained with one exception, and this was, strange to say, after a course of Phosphorus had been taken for a day or two, on this occasion the appearances were not so well marked. Stricker's and another warm stage were used, and every precaution taken to guard against physical scources of error. Counter experiments were made in cases of ordinary chlorotic anæmia, a case of extensive lymph-adenoma, and in one of advanced Phthisis is an example of a wasting disease.

The *Red Corpuscles* showed no tendency to collect into rouleaux, but formed instead masess of irregular shape; they were considerably *reduced* in number as compared with other specimens; they were very variable in size, and showed great diversity of form, some being oval, others pear shaped and drawn out to a point, those which were much altered in shape were much larger than normal .In all the abnormal corpuscles the normal uniform aspect was so far changed that the yellow substance appeared to be collected in some point of the corpuscle, so that the other part was left quite clear and transparent; this was especially true of those corpuscles presenting processes, the yellow colour of these latter parts being in nearly every case of a more intense yellow than the rest. No change in shape was observed in these corpuscles.

They believed this change of aspect to be only explainable by a separation of the hæmoglobia from the stroma, corresponding to the zooid and œcoid of Brücke. They further compare this separation to that produced by Tannic Acid in 2 per cent. solution on normal blood, in which case, however, an astringent is acting both on stroma and hæmoglobir. They believe that in the case described, the stroma is abnormally

soft, and that this state of stroma allows the hæmoglobin readily to coagulate and collect in parts giving the appearance described.

The *White Corpuscles* were of two sizes, both usually present in the same field:—(*a*) *Large*, resembling in every way ordinary leucocytes; never more than two were seen in one field, and in many fields they were quite absent; showed good amœboid movement. (*b*) *Small*, more numerous than the large, and present in every field; sometimes as many as 8 or 9 were observed; they were estimated at about a quarter the size of ordinary leucocytes, they were granular, sharply defined, and looked more like free nuclei, they showed no amœboid movement, floating about in every field were a larger or smaller number of bright homogeneous droplets, of irregular shapes and of a yellowish tinge. (*Lancet, May 5th.*)

TREATMENT OF ERYSIPELAS BY SALICYLIC ACID. Professor Petersen of Kiel, has in three cases cut short the progress of erysipelas by the subcutaneous injection of 15 minims of concentrated solution of Salicylic Acid, in the neighbourhood of the affected part, the injections were repeated several times in each of the cases. The experiment is worth trying in other cases of erysipelas. (*Med. Rec.*)

VON NUSSBAUM ON SHOCK. When reflex paralysis occurs after severe laceration of peripheral nerves, the condition is defined as the shock of the injury; if with fatal result we say death has resulted from the shock of the injury, and necropsy is not expected to afford any explanatory phenomena. Dr. Nussbaum refuses to attribute to shock all deaths from injuries, when, during a moderate period satisfactory progress has been made, and no danger has been perceptible. The presence of decomposing fluid in any tissue implies a disturbance of the normal nutrition, and this is true of the heart muscle.

In cases of very rapid septic peritoneal absorption, death is doubtless caused by septicæmic collapse, though wrongly attributed to pure shock.

Loss of blood in operations is often the cause of sudden death in old patients, of a day or two's good progress, though the cause is often said to be shock, a short interval being necessary for the production of the full effect. A similar sudden fatality attends severe railway accidents, and consequent amputation in even young and strong men, and is wrongly attributed to shock. Nussbaum and others believe it may be safely attributed to fat-embolism, the effects of which are seen in severe dyspnœa, œdema of lung, and sudden death.

The following phenomena are not to be confounded with severe shock to which they lead, but from which they are to be distinguished:—Septicæmia, Senile Anæmia, Fat-embolism Crushing of bones, and sudden cooling of abdominal viscera. (*Med. Rec.*)

NOTICE OF BOOKS.

TRANSACTIONS OF THE CREMATION SOCIETY OF ENGLAND.

EDITED BY W. EASSIE, C.E., SMITH, ELDER & Co. 1877.

This elaborate pamphlet, written in an able and energetic manner, proves that the cremation movement extends over a larger space, and shows more vigour than most people imagine. Certainly the society cannot boast of many cremations up to the present time, for they record but ten during the last decade, but the carefully detailed reports from different European countries, as given in this volume show that the consent of the various governments is only required, and cremation will become the popular method for disposal of the dead. From Italy the news is most promising, as several cremations have taken place unopposed by law; in fact "since March 1877, Cremations are allowed in Italy (Milan), provided that the Cremation Society and the relatives of the deceased make a joint application to the Prefect of the Province; and the latter can grant a license after due consultation with the provincial Sanitary Council."

In Germany the movement is evidently spreading, and Professor Kinkel is the Honorary President of the Society. In Gothas Cremation is now legally permissive, and the mortuary and Crematorium are being built. In Holland the greatest progress seems to have been made for the Society has branches in many towns, and an address has been forwarded to Parliament praying that Cremation may be legally performed, the Cremation Society of Holland consists of more than 1,300 members. Reports are also given from America, where no opposition seems to be offered by Government, and from Austria, Switzerland, Belgium, and France; in the last named country no great advance seems to have been made. A full report of the International Congress held at Dresden in June, 1876, is given, and is very interesting to read, as it shows with what enthusiasm the subject has been taken up, and how thoroughly well organised the whole movement is. This little volume also gives the plans, illustrated by wood cuts, of several incinerating apparatuses, and a full description of an immense Crematorium suitable for a population of 200,000; we must refer those interested, to the work itself for details.

A complete bibliography of every known published work bearing on Cremation and other methods of burial, is added, and would prove invaluable to any one getting up the subject.

The following particulars of two cremations are interesting and are taken from one of the tables in the book.

Female, æt. 35, weighing 116 lbs, was reduced to ashes which weighed 6 lbs., at Padua, in 1869.

Male, æt. 75, weight unknown, was reduced to ashes weighing 6 lbs., in 90 minutes, at Milan, in 1876.

HINTS FOR SURGICAL WARD CLERKS.

Of all the educational advantages that our *alma mater* offers to us Guy's men, probably none is so truly valuable as that unrivalled series of clinical appointments which begin with Assistant Surgeon's Clerk and ends with House Physician and House Surgeon. It is whilst holding them that we gain that training of eye, and ear and hand, so necessary to us hereafter as practical physicians and surgeons. And of these appointments the junior ones are not less valuable than those taken at a more advanced period of a student's career, and every endeavour should be made to utilise to the utmost the opportunities which they afford. With a view of aiding if possible my fellow students in making the most of one of these junior appointments that of Surgical Ward Clerk, I propose giving a few brief notes, derived from my own experience in the appointment, and embodying just what I should myself have cared to know. I know, that as a matter of fact, that many men take Surgical Ward Clerk before their First College is passed, and when most of them are profoundly ignorant of everything connected with clinical investigation. It is for them that these remarks are intended, and should they aid one junior man in his ward work, their object will be fully attained. To plunge at once in *medias res*, the first thing the reporter should do, after seeing his name up, will be to provide hinself with a clinical thermometer,

a spring measuring tape, and a good large note book. The thermometer should be obtained from a good maker, and care be taken that it is one the graduation marks upon which will not easily rub off. Those made by Carella of Holborn are the best I know. Next he will see a notice desiring him to meet the Surgical Registrar to be initiated into his new duties. At this meeting the clerks will be distributed to their respective surgeons. This is usually arranged by lot, but there is always plenty of opportunity for choice as some men are invariably ready to effect an exchange with those who desire to be under a particular surgeon. This is not a matter of much importance, but one or two points may be taken into consideration. A clerk to an assistant surgeon has not usually such good opportunities as one to a full surgeon. Again, under an antiseptic surgeon, from the necessity of the clerk being close at hand in the theatre to work spray he has an excellent chance of seeing operations. The choice of the surgeon made and the distribution of his wards mutually arranged, the ward clerk will be introduced to his beds by the registrar and should at once commence his duties. Briefly, they will consist in taking careful histories of all new patients on their admission, and of daily visiting them during their stay in the hospital, and noting any circumstance of importance in their progress or in the treatment adopted. He will be expected to go round his beds with the surgeon and the registrar and always to be present at operations of which he will always write full descriptive reports. A word or two now, about note taking for the student's own use. This is a most necessary practice if he wishes to derive full advantage from his appointment, and when he holds a dressership he will find a good selection of cases most valuable. I should advise him to eschew case books, the time for them is not yet. When he is full dresser or house surgeon will be quite early enough for those convenient tabulated forms, admirably adapted for recording those salient points which as yet he does not know how to recognise. The best mode is to provide yourself with an ordinary good sized note book. Divide this into spaces of 8 or 10 leaves according to its size. Allot each of these spaces to a case and take your history and day to day report into this *in extenso*. You will find it most inconvenient to carry an ink bottle, and your folio of report sheets round the ward with you, and besides good, succinct reports fit for your surgeon and registrar to examine can never be made unless you prepare a rough preliminary draft. Make this rough draft then, in your note book, instead of upon scraps of paper, and when you have finished your round copy it on your report sheets in such revised form as may be necessary. If you write in one page only of each leaf you will find that the notes will remain legible for an indefinite length of time, and as they are only for your own eye a few interlineations and erasures will be of very slight importance. If at any future time you have leisure to enter analyses of these cases into a proper case book by all means do so. With respect to taking the histories themselves you will often find more difficulty. Patients vary much in this respect, some seem instinctively to tell you just what you want to know, others require the talents of a cross examining barrister to extract any satisfactory particulars from them. As a rule the best mode is, after you have obtained the family and personal history to ask the patient to give an account of his illness in his own way. Do not interrupt him however much he may ramble from the point at issue, but carefully notice all he is telling you, and when he has finished endeavour by cross examination based upon his statement to elicit the facts you require. Always take care to distinctly separate objective from subjective symptoms. Everything coming under the former head should be put down, you will find it necessary, especially in female patients (who often exaggerate them very much), to eliminate a great portion of the latter. Beware of putting down a diagnosis in place of a discription of symptoms. This is an error that reporters too frequently fall into. For instance, they will sometimes put down off hand that a fracture of the shaft of the femur was discovered, instead of describing shortening, deformity, crepitus, too free mobility, loss of power or other signs present in the injured limb. This is sufficient to show what I mean, and is an error that you cannot be too careful to avoid. In injuries, deformities suspected new-growths and other cases it is a very good rule always to carefully compare the affected side with the opposite one. The histories of children may be best obtained from their friends at the time of admission, or on subsequent visiting afternoons. With respect to all patients, one golden rule should always be borne in mind, viz., to take the history whenever possible immediately after admission. The aspect of many surgical cases, more especially of accidents may change materially in a few hours. Accidents unfortunately are just those cases in which this rule is most difficult to carry out, inasmuch as they come in at all times, and in a large number of cases during the night. If, however, you are reporting in an accident ward it is well during your surgeon's taking in week to look in several times in the course of the day as well as on Sunday, whilst if you live within a reasonable distance you may easily pay a visit to your ward the last thing at night. In those cases which you cannot possibly see on admission you must have recourse to the dresser who will almost always be ready to give you any information in his power, After the history is once taken never let a day pass without visiting each one of your cases. I do not mean by this that you are expected to make an entry daily, on the contrary, in many cases you may even have no particular worthy of record for many days, or even weeks, but remember that if any complication does arise you are expected to be fully acquainted with it. Be always observant of

such details as the way in which a patient passes the night, or the amount of food that he takes. For information upon these points you must have recourse to the Sisters who are invariably most obliging.

One time of visiting your ward should be as closely adhered to as possible. This should be in the morning, and the best time to begin is about 10. The dressers usually begin their work about that time, and the reporter then has an opportunity of seeing the dressings at least occasionally. This is a most important advantage, as of course he must never disturb a dressing on his own authority, and besides much valuable information as regards the details of dressing, may be obtained more especially if the ward clerk is careful to cultivate amicable relations with the dressers, which I should most certainly advise him to do. In the wards of an antiseptic surgeon the reporter will be expected to be at hand to work with the spray producer. This much despised employment appears to me to be of the most advantage, as it gives him the opportunity of closely observing all the proceedings of the surgeon and dressers, and this more especially in the operating theatre is a most valuable privilege. The clerk should never omit to accompany his surgeon in his rounds. If he does, he fails in a very important part of his duty, and loses much of the advantage accruing to him from his appointment. Take careful note of all the remarks your surgeon makes, and anything bearing upon your cases may with advantage be put down on the alternate page, which I advised you to leave blank in your note book. The same remarks apply with equal force to the rounds of the Registrar. You should never fail to have every report posted up ready for him, and should make a point of eliciting information upon every point in your cases that is not perfectly clear to you. He will at each visit collect the completed reports, and these should always be properly filled up, in the case of discharge, with a full account of the patient's condition, and a comparison of his symptoms with those recorded on admission, and in the case of death, with a description of circumstances under which it occurred, and of the post-mortem appearances observed. Before leaving this part of the subject, I must refer the student to the very excellent tables issued to each clerk, as aids to methodical and accurate observation. He should refer to them continually, whilst making his reports.

I propose now to make a few brief remarks upon what may be called the manipulative part of a Ward Clerk's work. With regard to the use of the clinical thermometer, but little would seem necessary, although I have seen a reporter taking temperatures with the bulb of the instrument uppermost, and another quietly setting down the abnormally low-temperatures indicated to him by the inferior extremity of his index. Some difficulty may occasionally be met with in children, or in cases in which both axillæ are blocked up by a splint. In the last take the temperature under the tongue, in the popliteal space, or in the inguinal fold. The thermometer should be kept in situ about five minutes, and you must be careful that it is not shaken out of position during that period. In children or restless patients, it is advisable to keep the patient's arm still with your hand. Always record your temperatures in the back of the bed letter for the convenience of the House Surgeon or dresser. After operations the temperature should invariably be taken daily, until it becomes normal.

The clinical examination of urine you will find necessary in many cases. The points you will have to observe will be quantity, colour, deposit, specific gravity, reaction, presence of albumen, sugar, pus, blood corpuscles, tube casts or crystals. All necessary apparatus will be found in the Registrar's room. When you require urine for examination, give directions to the nurse, who places it in a conical glass ready for you. The specific gravity will be ascertained by means of the urinometer. In normal urine it ranges from 1015 to 1025. For albumen the best mode of testing is to add a few drops of nitric or acetic acid, to the suspected urine in a test tube, and then to boil it over a spirit lamp. By the proportion that the precipitated albumen bears to the whole quantity of urine taken, you will be able to form a rough estimate of its amount, which must be expressed in fractions. Always examine for albumen before operations. To detect sugar, boil a small quantity of Dr. Pavy's solution (Lig Pavii) in a test tube, and then gradually add about an equal quantity of the suspected urine. If sugar be present, a precipitate of a deep reddish yellow colour will be found. The presence of pus in any quantity, may be demonstrated by the addition of a small quantity of Liquor Potassæ, when a thick glairy mass is formed. The pus cells under the microscope are characteristic. They are somewhat larger than blood corpuscles, faintly granular all over and if you introduce a little acetic acid at the edge of the slide, two or three distinct circular nuclei will come into view. With the appearance of blood corpuscles most students are familiar. As seen in urine, they are mostly somewhat altered in form, being indented round the edges like a cog-wheel. Be careful not to mistake albumen resulting merely from the presence of pus or blood, for that due to kidney disease. If in doubt always examine for pus and blood, sometimes you will have to look for tube casts as an indication of renal disease. These under the microscope are large, somewhat oval tubular bodies composed of fibrine, which has coagulated in the kidney tubules. Occasionally owing to their transparency, you will have some difficulty in making them out. Tilt one side of the slide up so that the light will be transmitted through them obliquely. and they will usually be brought into view. The microscopic examination of urine for crystals, will often be necessary, especially when you wish to ascertain the nature of a calculus. Those most

frequently met with are uric acid, triple phosphate and oxalate of lime. Uric acid crystals are of a red or deep yellow colour and most frequently lozenge shaped. Triple phosphates are quite transparent, and usually prism shaped. Often, however, they have a serrated stellate appearance like a star fish. Thep are easily dissolved by the addition of acetic acid. Oxalate of lime crystals have generally a typical envelope shape, and less frequently a distinctly "dumb bell" form. In the examination of all urinary deposits, be careful to let the urine stand for some hours, and to plunge your dipping tube quite to the bottom of the glass containing it.

A word or two about the stethescope may not be out of place. Although not often called for in the surgical wards, it is advisable to carry one and to examine by ausculation and percussion all your surgical patients. In this way you will gain a valuable familiarity with the sounds of the healthy chest, and be able to appreciate those morbid deviations which in the medical wards you will be required to study.

Athletics.

A meeting of all interested in athletics was convened for Monday (June 4th), and a large number attended. Mr. Hicks took the Chair. It was proposed and carried, that the Hospital should hold its sports this year about a week before the United Hospitals' Sports. Mr. Grey was re-elected secretary, and an unanimous vote of thanks accorded him for his services during the past year. A Committee was then elected as follows:—

1st year, Stokes and Fraser.
2nd year, Boswell and Scott.
3rd year, Howell and Wilkinson.
4th year, Keen and Gravely.
Above 4th year, Pescott and Gilbert.

Mr. C. Lloyd Jones, an old representative at the U. H. Sports, was also added and elected Chairman.

The Secretary reported a balance of £16.

The proceedings closed with a vote of thanks to Mr. Hicks for his courtesy in taking the Chair.

At a Committee Meeting held on the following day, it was resolved to hold the sports on the 28th and 29th of the present month, at Lillie Bridge, or Stamford Bridge, as should prove on enquiry to be most convenient.

Subscriptions were ordered to remain as last year (7/6 and 5/-), and a member of the Committee was deputed to wait on the staff, and beg their co-operation.

It was also determined to request the Treasurer to become President of the Club.

We most sincerely hope that the movement will be successful, and that by the energy, perseverance, and pluck of our athletes, we may see in its old position the Challenge Shield, for four years, alas, absent from its accustomed nook in the library, to form a worthy companion of the Football Cup, which our men carried off in so brilliant a manner this winter.

"*Dare quam accipere*" is indeed the motto of the Hospital, but the Guy's men's heart rebels at this pious maxim, when he is required to act up to it in the case of the Shield and Cup.

The programme of the Guy's Sports is arranged as follows for the 28th or 29th of June:—

100 yards flat race.
Quarter of a mile flat race.
120 yards Hurdle race.
One mile flat race.
Putting the Weight.
High Jump.
Broad Jump.
* 250 yards flat race.
* Half-mile flat race.

* Open to all Amateurs.

ON DUTY FOR JUNE.

House-Physicians:—W. A. Kidd, M.B., T. L. Porter, M.R.C.S
Junior House-Physician:—C. F. Pickering, L.R.C.P.
Senior House-Surgeon:—M. Lubbock, M.R.C.S.
Junior House-Surgeon:—W. P. Reynolds, L.R.C.P., M.R.C.S.
Senior in Charity:—W. C. James, M.B.
Junior in Charity:—C. G. Lee, L.R.C.P.

DRESSERS FOR THE WEEK.

May 30th, Mr. Hammersley (Mr. Durham).
June 6th, Mr. O. Bowen (Mr. Howse).
„ 13th, Mr. Sheldon (Mr. Forster).
„ 20th, Mr. J. Poland (Mr. Bryant).
„ 27th, Mr. Birdwood (Mr. Durham).

NOTES FROM THE WARDS.

We propose giving, in future, a short account of interesting cases in the Wards, as they occur at the time of publication of the *Gazette*. The report each month will include cases under one or more Surgeons or Physicians, according to its length, and cases will be chosen which will be in at our date of issue, so that men can follow up any particular case or set of cases by personal inspection.

Professor Lister made no mistake, at any rate in one statement, when he said that London presented a magnificent field for clinical demonstration, and Guy's at this time gives every opportunity for clinical observations in its large number of occupied beds.

CASES UNDER Mr. BRYANT.

JOB.—3. Disease of the left hip of 6 months standing; in May, Mr. BRYANT cut down and removed several necrosed bits of bone from the bottom of the acetabulum, and was able to put his finger into the cavity of the pelvis; the head of the femur felt rough, but it was left in situ; Mr. BRYANT hopes that after removal of all diseased pieces of bone from the acetabulum, anchylosis of the joint may occur; the boy is in a double splint, and is doing well at present.

JOB.—4. Extensive cancer of the tongue in a man æt. 36. The whole organ was removed 3 weeks ago, by means of the wire ecraseur, through a small incision made in the left submaxilliary region, a mass of suspiciously indurated glands under the chin were observed at the time of operation, have since softened and disappeared; the slough separated without any hæmorrhage; the small bit of root of tongue that is left is very hard.

JOB.—5. Disease of right Hip in a boy æt. 14, treated by excision during the active stage of suppuration in the joint, the boy has done well, and there is movement in the new joint.

JOB.—7. Case of *obstruction of the intestine (small?)* transferred from the medical wards, where the man æt. 68, had been under the care of Dr. WILKS for some months. A

short incision was made by Mr. BRYANT in the right lumbar region, a piece of intestine was hooked up, tied to the edges of the wound, and an opening as large as a pea made in it, no symptoms of peritonitis since the operation (April 29th), and the temperature has never gone up, yellowish granular matter is passed through the wound, and much intestinal juice at variable intervals; during the last fortnight, also fæces have been passed per anum without pain or trouble. The terrible griping pains present for so many months, have quite disappeared, and the man is now comparatively comfortable. An apparatus is being made to fit over the opening in the side, the man will then be allowed up. This operation goes by the name of "Nelaton's operation." It is thought that the lower end of the Ileum has been opened, judging by the character of the matter expelled through the opening.

JOB.—9. Very extensive bursa on left shoulder of a man æt. 43; he is a barge man, but denies carrying heavy weights on his shoulder. He came in with a large fluctuating swelling over the acromion in front, and extending down to the angle of the scapala behind, a peculiar thrill could be felt on pressure as if loose bodies were present in the tumour; movement of shoulder perfect and not painful. An opening was made over acronion and Mr. BRYANT on inserting his finger could feel the head of the humerus and the various parts of the joint very distinctly, the capsular ligament apparently alone intervening; he made out that the bursa extended under the deltoid, below the spine of the scapula and down the dorsum, a counter opening was therefore made at the angle, and a quantity of thin bursal fluid with curdy bits ol lymph evacuated. Treatment by a drainage tube through both openings is now carried on.

JOB.—21. Compound comminuted fracture of left patella in a boy, followed by necrosis of outer edge of patella, and acute suppuration of the joint. A sequestrum, evidently the outer edge of the patella, was removed a few weeks ago, but the temperature went up soon after and the joint suppurated, so that on June 2nd, free incisions were made into it, and about 2oz. of pus evacuated; the temperature has gone down steadily since the incisions, and the boy is now free from pain.

JOB.—25. Strumous disease of Epidydimis in both sides, effusion into the left tunica vaginalis; on examimation per rectum, both vesiculæ seminales can be felt to be hardened and knotty.

LYDIA.—1. Enlargement of bursa under right gluteus maximus. The woman came in two years ago with obscure trouble about the hip, but as nothing could be made out was discharged after some time. The swelling was opened and a drainage tube is now inserted.

LYDIA.—2. Large abscess in a boy æt. 6, pointing in a left inguinial region and extending right up into the loins; when he came in the boy was very well and was able to run about like any other child, on June 5th, Mr. BRYANT made an incision just above the left anterior superior spine and found the abscess to be situated very deeply, deeper than the muscles, either in front of, or behind the transversalis fascia.

LYDIA.—5. Case of a boy who was shot in the face on the 27th of April, the rook-gun contained powder and brown paper wad, and was held about a foot from the child; the left eye was found full of blood on admission, and the cornea has since sloughed away; the right eyeball was apparently not much wounded, there is now anterior synœchia on that side, a large ragged hole was made by the wad at inner side of right orbit, and this has since granulated up very well; the powder has caused a complete circle of blue spots on the boy's face.

LYDIA.—7. Fine example of adenoma of mamma. A bossy tumour as large as a child's head occupies position of left mamma of two years duration, and commencing soon after the weaning of a baby, the woman æt. 35, has since had another child, but the tumour did not materially increase during the pregnancy, the skin is tightly stretched but not adherent, the nipple is not drawn in, the whole tumour is freely moveable it is not painful, no enlargement of axilliary glands, and no apparent cachexia, no history of carcinoma. She has just weaned her baby, and she says that the affected breast contains a little milk; several small arteries can be observed pulsating over the surface of the tumour; the woman's general health is good.

LYDIA.—15. Impacted fracture of neck of left femur occurring in a woman æt. 63, six weeks ago; it was treated as a contusion of the hip. The woman was knocked down and fell directly on left trochanter, she was picked up, but fell again on the same place before reaching home; she was not able to walk or bear any weight on that leg, and was not able to lift the limb. On admission, she cannot bear weight on that leg, she is able to raise the leg slightly from the bed, there is slight eversion of the foot, complains of pain in inner side of thigh on movement. Evidence of fracture, mass of callus in digital fossa, shortening of the limb to extent of ¾ inch, and by measuring the Ilio-femoral triangles, the base shows ½ inch difference on the left side.

STATISTICAL REPORT OF THE SURGERY DURING MAY.

The following tables will, we feel sure, prove of interest to our readers, if only to show the extent and variety of the valuable practice of our Surgery during a single month. We need, therefore, offer no excuse for their publication.

The cases tabulated have all been treated as out-patients, and are exclusive of all accidents and surgical affections, which were of such a nature as to demand or necessitate admission. The Dental Practice recorded is also exclusive of all those cases seen by Mr. Moon.

MALE SURGERY.

Fractures:—		Leg	13
Rib	8	Ankle	32
Clavicle	4	Foot	19
Humerus	2	Crushed fingers	20
Olecranon	1	Amputation of fingers	8
Ulna	1	Wounds of all kinds	123
Radius	2	Cut heads	66
Radius and Ulna	2	Punctured wound of elbow joint	1
Colles'	1	Bites:—	
Phalanges	2	Human	4
Tibia	1	Dog	11
Metatarsal bone	1	Horse	2
Lower jaw	5	Donkey	1
Compound Fractures:—		Cat	1
Radius and Ulna	1	Burns	14
Phalanges	4	Scalds	2
Dislocations:—		Foreign bodies:—	
Shoulder	1	In eye	8
Elbow	1	Swallowed	3
Patella	1	In throat	3
Injuries (*i.e.* Contusions, Sprains or Strains):—		In finger	1
Head	3	In hand	1
Face	9	In abdominal walls	1
Neck	3	In nose	2
Chest	7	Polypus nasi	1
Abdomen	2	Circumcision	1
Side	26	Paraphymosis	5
Back	13	Ruptured frænun	1
Shoulder	25	Orchitis	8
Elbow	11	Stricture	13
Arm	19	Cystitis	1
Wrist	22	Bubo	2
Hand	11	Hydrocele (tapped)	6
Finger	17	Bubinocele	1
Thigh	8	Inguinal hernia	4
Knee	26	Contusion of perinæum	1

Prolapsus ani	2
Poisoned hand	4
Poisoned arm	3
Palmar abscess	4
Thecal abscess	1
Abscess (of other varieties)	6
Bursitis	3
Inflammation about elbow	1
Facial erysipelas	1
Black eye	4
Wounds of eye	4
Conjunctivitis	2
Ophthalmia	1

Total number of Cases seen in the Male Surgery, 869.

FEMALE SURGERY.

Fractures :—	
Rib	1
Clavicle	10
Humerus	1
Radius	4
Ulna	2
Radius and ulna	1
Colles'	3
Femur	1
Greenstick fractures :—	
Radius and ulna	1
Compound fractures :—	
Radius	1
Dislocations :—	
Clavicle from scapula	1
Elbow	1
Thumb	1
Injuries (*i.e.* Contusions, Sprains or strains) :—	
Face	4
Neck	1
Abdomen	1
Side	8
Back	2
Shoulder	10
Elbow	3
Arm	9
Wrist	6
Hand	10
Finger	3
Thigh	3
Knee	11
Leg	5
Ankle	11
Foot	2
Crushed fingers	2
Wounds of all kinds	28
Ostitis	3
Epistaxis:—	
Anterior Nares (plugged)	2
Posterior Nares (plugged)	3
Divided ulnar artery	1
Ruptured varicose vein	1
Hæmorrhage(other varieties	1
Ulcerated legs	4
Run over (no injury save shock)	3
Tumour of upper lip	1
Teeth extracted	122
Medical cases	62
Cut Head	5
Bites :—	
Human	1
Dog	3
Cat	1
Burns	8
Scalds	6
Foreign Bodies :—	
In eye	1
In ear	1
In nose	1
In finger	4
Tongue tied	4
Paraphymosis	2
Bubonocele	1
Umbilical hernia	2
Inguinal hernia	2
Thecal abscess	4
Mammary abscess	2
Abscess (other varieties)	3
Inflammation about elbow	1
Facial erysipelas	2
Bursitis	1
Synovit of knee joint	3
Strumous disease of knee	1
Hip joint disease	4
Gumma over Tibia	1
Angular and Lateral curvature	1
Ganglion of wrist	2
Conjunctivitis	2
Effusion of blood into anterior chamber of eye	1
Ruptured varicose vein	1
Teeth extracted	104
Medical cases	22

Total number of cases seen in the Female Surgery, 344.
Total number of cases seen in both Surgeries, 1213.

STATISTICAL REPORT OF LYING-IN CHARITY FOR APRIL, 1877.

Number of women attended		204
Recovered	203	
Died	1	
	204	
Single Births		202
Dual		4
		206

Women attended in 1st confinement		29
" " 2nd "		25
" " 3rd "		35
" " 4th "		24
" " 5th "		20
" " 6th "		18
" " 7th "		14
" " 8th "		11
" " 9th "		11
" " 10th "		4
" " 11th "		7
" " 12th "		2
" " 13th "		2
" " 15th "		1
" " 17th "		1
		204
Children at full time.		
Males alive	98	202
Males dead	2	
Females alive	101	
Females dead	1	
Premature children, 7 and 8 months		
Males alive	0	3
" dead	0	
Females alive	2	
" dead	1	
Abortion		1
Total number of children		206
Alive	204	206
Dead	2	
Presentations.		
Vertex	194	
Face	4	
Breech	2	
Foot	3	
Elbow	1	
Vertex and hand	2	
	206	
Operations.		
Turning	1	
Craniotomy	1	
	2	

Externs attended.	
Mr. J. Alexander	46
Mr. J. F. McCrea	45
Mr. W. A. Davis	41
Mr. C. J. Plummer	37
Mr. C. St. J. Wright	35
	204

CHARLES W. LACEY,
Junior in Charity.

BROCK—HUBBUCK.—May 22nd, at the parish church, Greenwich, J. Brock, M.R.C.S. England, of Guy's Hospital, to Elizabeth Abigail (Liccie), daughter of W. A. Hubbuck, Esq., of Rosenthal, Catford, Kent.

GIBB—JONES.—May 16th, at Holy Trinity Church, Tunbridge Wells, Robert Charles, son of the Hon. J. M. Gibb, of Vere, Jamaica, to Sophia Anne S., daughter of J. Jones, Esq., J.P., Dymchurch, Kent.

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FIG. 1.

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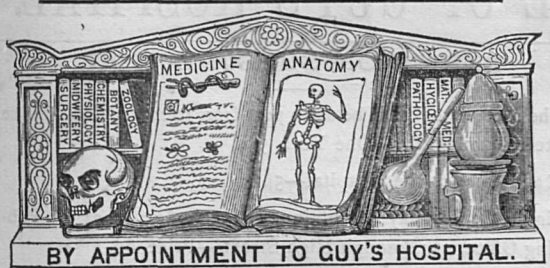

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Clinical Surgery.

Dr. Fagge took for his subject a case of dysentery which is now in Clinical ward. He commenced by reading the report of the case, which is shortly this: V.R.S., 45 years of age, sailor, who has been abroad a great deal in the tropics, has been suffering for the last six months with the ordinary symptons of chronic dysentery. He thinks he brought it on by getting wet and cold on deck, often sleeping out at night. He has been getting thinner and weaker lately. He has had ague and "coast" fever. On admission he had ten to twelve motions daily, stools liquid, but not bloody nor purulent. He was kept in bed on milk diet for some days, but getting no better and being rather impatient was given drachm doses of Tr. Lavandulæ Co. He very rapidly improved, and in three or four days stools became nearly natural and bowels only opened twice a day. He is still in the hospital (May 24th), but is desirous of leaving as he feels quite well.

In describing dysentery it may be as well to first point out the morbid changes that have been noted. It consists essentially of inflammation of the larger intestine, sometimes small intestines too may be affected, especially lower end of ileum. Aitken and Maclean state that it is only in Scorbutic dysentery that the small intestine is affected; but this has not been confirmed at Guy's. It generally begins in the rectum and spreads upwards, but may be reversed. Virchow divides dysentery into two kinds, catarrhal and diphtheritic. These, however, are not distinctly different from each other except in intensity, so that we find various grades of the disease, the catarrhal prevailing at one time, the diphtheritic at another.

Catarrhal.—Dark red patches, black points, all folds and ridges injected, over all a thick layer of mucus streaked with blood. In earliest stages the blood-vessels are dilated and filled with blood, mucous membrane swollen, solitary glands enlarged, appearing as white points with red rings round them. Submucous tissue is greatly thickened, even muscular coat is swollen and thrown into folds, all the tissues are filled with pus cells, especially in spaces round the vessels, the lymph sinus round each solitary gland contains no pus. Cruveilher said solitary glands took no part in process. Dr. Parkes said they were earliest affected, and he has been confirmed by Dr. Baly. Probably they are only affected as a part of a general inflammation of the mucous membrane. The roofs of these glands give way, and so minute holes are produced, leading to a cavity containing the substance of the gland itself, which sloughs, leaving a yellowish ulcer, whose floor is submucous tissue.

Diphtheritic.—Do not mistake the meaning of this term as applied by Virchow to dysentery; it is by no means synonymous with Diptheria which is a throat affection. It is simply a morbid change of a particular kind, probably dependent merely upon intense irritation of the part. The whole thickness of the gut is affected from the first, causing bowel to be hard and massive, serous surface intensely injected, then red fluid in interior, lining of bowel is greyish red and appears raised from surface. Intestinal contents may stain it yellow, green, or red, or black. All coats of gut are thickened, but especially internal coat. Under microscope one finds extravasated blood in walls, fibrine and pus, and double layers of cylindrical cells corresponding to Lieberkühn's follicles. The fibrinous material is said to contain bacteria, and that they are essential in the production of the disease, probably they have to do with putrefaction, nothing more. The parts affected necessarily die, and so eschars are formed which slough off as shreds and detritus into the bowel leaving ulcers. It is easy to see how abscesses may thus form, burrowing their way between the walls of the gut, or actually perforating into the peritoneal cavity and so causing fatal peritonitis, or may set up neighbouring inflammation and suppuration and thus we get abscesses in various parts. The citratrices left by these ulcers are often dark coloured, even black, owing to the chemical action of the sulphurretted hydrogen in the intestine, on the colouring matter of the blood.

Dysentery may be Sporadic, Endemic or Epidemic.

Sporadic.—This is as a rule the mildest form; and Heubner goes so far as to say it never occurs under the Diphtheritic form; this is not so, as cases have occurred at Guy's of this kind during the last twenty years. It is said to be caused by eating fruit, raw meat, &c. Trousseau objects to such causes, saying they could hardly pass all through the small intestine without setting up irritation, and then cause dysentery in the large intestine. But we have evidence of such a thing being possible in the fact that corrosive sublimate and white precipitate will leave the small bowel intact, and yet cause severe irritation in the large bowel; and one can easily understand that the torpidity of the large intestine, permits of much greater facility for the action of irritants, than the rapidly moving small intestine which quickly carries down a noxious body; and again for some reasons the flexures of the large intestine which may be supposed to be more stationery than other parts, are most severely and earliest attacked. Cold will produce it as is exemplified in the case now in Clinical.

Endemic Dysentery has its home in the tropics, in a zone 35° or 40° on each side of the equator, especially when the nights are hot and the days cold. It occurs at all ages, but attacks mostly the weak, the old, and the intemperate. There may occur epidemics, both in those places where it is endemic and in those where it is usually sporadic.

Is there a specific cause for dysentery? We know that it rarely, if ever, passes from the sick, to their attendants, or from the military to the civil population

in times of war. Leibermeister in Ziemmsen thinks it is infectious, though local just in same way as gonorrhœa and soft chancres. The sporadic is said to be related to the epidemic form, as English to Asiatic cholera. The incubation varies from two to eleven days. *Symptoms.*—Diarrhœa at first for two or four days, may be longer, weakness, malaise, straining at stool, and passing little. Tenesmus in the sense of feeling, as if one wanted to pass something, the patient may be always trying to pass something, and yet he passes very little during the twenty-four hours: 28 to 42 ozs. (Heubner) fluid fæces indicates implication of small intestine, and is therefore unfavourable, mucous, blood, and red masses looking like pieces of sodden flesh, may be passed. Pus generally mixed with fæces and blood, but occasionally pure, pellets of mucous, like boiled sago which were formerly thought to be sloughs of solitary follicles sometimes discharged; or a brownish-red fluid, horribly offensive, indicating sloughing. Dysenteric stools are always peculiarly offensive, and Dr. Fagge thinks he has noticed the same offensive smell in cancer of the rectum. These symptons may be all, or any of them absent; sometimes there is strangury. The most marked symptoms are prostration, anæmia and faintings, the patient often fainting whilst at stool; a pale waxy look, very thirsty and feverish, griping pain, especially after taking food so that only the blandest nourishment ought to be administered, and all liquids should be given warm, as cold will cause similar gripings. An affection like Acute Rheumatism affecting several joints is an occasional sequela; they are not very tender nor swollen, during convalescence parotitis may occur. In fatal cases the prostration passes into collapse, the features becoming sunken, cold sweats come on, and fœtid exhalations, urine is suppressed, sordes, hiccup, construction in epigastrium, involuntary stools, prolapsus ani, bed sores, excoriation about genitals, and death, consciousness generally retained till death, and sometimes for a few hours before death there is a feeling of great improvement.

Prognosis.—The severity of the local symptoms is no guide, presence of scurvy is unfavourable, and is sometimes spoken of as a distinct form, "Scorbutic Dysentery," it is slow in its course if scurvy complicates it: death as a rule takes place in the first week. In chronic dysentery, which is very intractable and often proves fatal by exhaustion and hectic, we may get hepatic abscess, Brights disease, lardaceous disease, or perforation and peritonitis.

Treatment.—Hygienic, warm clothing, temperance, avoidance of chills, and constipation.

Dr. Austin Flint found that patients got well just as soon whether he gave drugs or not. Maclean got different results; he gave 20 to 30 grains of ipecacuanha with syrup of orange peel, having if necessary prepared the stomach with a little opium previously given, the patient is then kept very still with a poultice on abdomen, and is not allowed to drink anything for three hours, after which some mild nourishment is given. Repeat the drug in 8 or 10 hours in a smaller quantity it may have to be given for several days, if vomiting follow its administration suspect hepatic or malarial disease; and if the latter give quinine accordingly. In mild cases a hot bath, ipecac and opium, and turpentine stupes are often sufficient; the tenesmus is relieved by enemata of starch and opium. How ipecacuanha acts is unknown; Maclean thinks as an evacuant increasing the secretions; it has had wonderful results abroad. In malignant cases Maclean recommended pernitrate of iron in ten minim doses every hour, castor oil, tamarinds, rhubarb, sulphates of potash and soda are necessary, whilst calomel, opium and venesection have been given up as systematic methods of treatment. Change of climate is often useful in Chronic Dysentery, and especially a voyage to Europe if the patient reside in India.

Astringents are useful; such as Iron, Krameria Catechu, Hœmatoxylou, Lead acetate, Tannic acid, Cupric sulphate, Bæl fruit, &c. Dr. Ward mentions enemata of nitrate of silver (gr. iv, adley ℥jj,) as useful, given at night time.

CASE OF INTESTINAL OBSTRUCTION TREATED BY OPERATION.

Under the care of Mr. Bryant.

W.B. æt. 57, by occupation, master builder.

Family History, good; no history of malignant disease:

Personal History. Has always enjoyed good health. Patient was admitted into Stephen under Dr. Wilks on the 5th of February, for constipation, sickness and violent abdominal pain. He began to suffer 6 months before admission, and the first attack came on suddenly after dinner one day, with violent pain in the abdomen, which was hard and swollen, and vomiting. From this time (September) up to christmas, these attacks came on periodically about once a week, bowels during this time were constipated. After christmas the attacks became more frequent, twice a week or more, the vomit was of a watery description, but never had a fæcal odour. He took many powerful purgatives, but none opened his bowels freely; they caused him no pain. On an average he had a motion every four days.

On admission.—February, 5th. Patient is a large, thin man, with a sallow complexion, resembling in colour that associated with the so-called "Cancerous Cachexia;" he says he has lost flesh very much lately. The abdomen is a good deal distended, and on palpation the coils of intestine can be felt. The Recti muscles are hard and resistent, and the abdominal walls generally, also. Has had no motion for four days. Has never passed any blood. No ascites. Nothing

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can be felt *per rectum*. Lungs and Heart, normal. Has violent pains in the abdomen, chiefly in the middle, and they are immediately followed by vomiting, sometimes "as much as a pail full" he says.

Treatment.

February 12th.—Injection every morning, but it does not bring much away. Pil Opii. h.s.s.

February 26th.—Constipation still continues with sickness and swelling of abdomen. Ext-Belladonnæ gr. ¼ ter die.

March 19th.—Passed a good solid motion, better than he has done for some time, this gave him great relief. Ext-Nucis Vomicæ. Ext-Opii. gr. ½ fis die.

March 26th.—This morning he again passed a good motion (after an aperient draught), great relief, good night.

April 5th.—Has been better during last week, bowels freely open, less abdominal distension, to take the pills ter die.

April 11th.—Abdomen not nearly so tense, bowels act well and frequently, no sickness for some time.

April 16th.—Is very bad, great pain, vomiting a great deal, bowels open.

April 18th.—Rather better to day, bowels open freely. Pil. Saponis Co gr. v.

April 20th.—Vomiting again, in great pain, bowels confined.

April 23rd.—Better again to day, no vomiting since 20th.

April 26th.—Very bad again; operation decided on.

April 28th.—Admitted into Job.

On the 29th of April Mr. Bryant determined to operate and to open the intestine by the operation known as Nélaton's, and he performed it very much in the way described by Trousseau in the 4th volume of his Clinical Medicine. "An incision is made on the *right side*, a little above the crest of the ilium, and parallel to Poupart's ligament, the length of the incision should not be more than eight or ten centimetres (3 inches). In dividing layer by layer, the skin, the cellular tissue, the muscles and apineuroses, tying, as may be required the large vessels involved in the incision, we at last come to the most deeply placed apineurosis. Proceeding always very slowly, this apineurosis is cut through, when forthwith the peritoneum is reached. It is taken hold of by a small forceps and incised; afterwards, using the greatest precautions, a silver thread, by means of a curved needle, is carried first through the intestine, and then through the abdominal walls; four sutures are then made, two on each side of the incision, then again two others, one at upper part of incision, the other at the lower part; but this time the abdominal walls are first perforated, then the intestnie, and then the abdominal walls on the opposite side of the wound. *It is then only neeessary to make an exceedingly small incision in the intestine* by means of a bistoury, the opening which M. Nélaton makes in the intestine for the passage of its fluid contents is even less than one centimetre in length."

Mr. Bryant modified the operation slightly by first fixing the intestine above and below by fine silk sutures passed through the outer coats of the intestine alone; and he also passed a curved needle armed with a double *Silk* thread through the intestine, instead of a silver thread. The wall of the gut was very thick, hypertrophied in fact from the extra work thrown on it, the incision therefore must have been above the seat of obstruction; from the appearance of the discharge it was thought that the lower end of the Ileum was opened. The wound was simply covered with oiled lint, after Mr. Bryant had put a catheter through the wound into the lumen of the intestine upwards and downwards to see if he could feel any obstruction.

To take Pil. Opii. gr. i 4 tis. horis si opus sit.

April 30th.—Very comfortable this morning, has had no pain; passed some liquid fæces through the wound. Takes nothing but milk. Temperature 98·4°, Pulse 66.

May 2nd.—Still very comfortable, says liquids seem to pass through the wound very soon after he swallows them. Milk diet. Has not been sick. Tongue clear and moist. Temperature 97·6°. Pulse 74, full and soft.

May 6th.—Patient much the same. Wound is painful, and so much discharge of liquid fæces come from the wound that he says the bed is literally swamped sometimes. Diet Milk and Jelly. Temperature 98·4°, Pulse 86.

The man went on uninterruptedly well, never having had any peritonitis, or rise of temperature. The chief inconvenience is from the large quantity of intestinal discharge which irritates the skin all round, and which gushes out sometimes with great force. To obviate this an apparatus was made in the shape of a truss, with an oval cup to fit over the wound; it does not act very well, and another instrument is to be made.

THE RELATIVE MORTALITY OF LARGE CITIES.

The medical director of Philadelphia has prepared an interesting table of the annual death-rates per 1,000 (*a*) from all causes; (*b*) from typhoid and diarrhœal affections; (*c*) from zymotic diseases during the spring and summer quarters, for London, Philadelphia, Chicago, and other cities. The annual death-rates are calculated as follows: for London 23·40, for Philadelphia 23·48, for Chicago 24·27, Boston 24·48, Baltimore 24·80, Paris 25·16, Brooklyn 26·91, New York 30·73, and for Berlin the excessively high rate of 34 32 per 1,000 population. The annual death-rate from typhoid and diarrhœal affections in all these cities are, with the exception of Paris, uncommonly high as compared with London, as in London it was only 1·66, and in Paris 1·76 per 1,000, whilst in Philadelphia it was 4·84, in Chicago 6·44, in Boston 5·56, in Baltimore 6·91, in Brooklyn 7·74, in New York 8·52, and in Berlin 10·92. It is to be regretted that typhoid and diarrhœa are grouped together, as we know that the mortality from the latter disease corresponds very closely during the summer months with the mean temperature, so that we should have expected a high rate in many of these cities, when the mean temperature of Philadelphia in each of the four weeks ending July 22 was 80°, 83°, 83°, and 81° respectively, giving an average of 81·75° against 75·5° Fahr. which was the mean in the previous year. The difference in the annual death-rates from zymotic diseases was more

striking even than the other rates, as in London it was only 0·62, in Philadelphia 6·47, in Chicago 9·9, in Boston 8·73, in Baltimore 8·37, in Brooklyn 11·81, and in New York 12·79. Those for Paris and Berlin are not given.

It is very evident from the above summary that London is a singularly healthy city when compared with other large and crowded places, and that, considering the enormously increased number of the population, and the comparatively short period during which active sanitary measures have been carried out, we have much reason to be satisfied with our death-rates. There is, undoubtedly, much room for improvement, but the experience of other cities certainly tends to show that calculations such as those lately made for "Hygeia" are utopian, and likely to mislead, or at any rate to result in disappointment. The medical director of Philadelphia considers the statistics he has given are highly satisfactory, and that these favourable results have been obtained from the "great efforts which have been made by the municipal authorities, as well as by those in charge of the Exhibition grounds, to obviate any cause of disease." Most certainly the comparison as regards the annual death-rates from all causes is eminently satisfactory, but it will be considered by no means so by those who are of opinion that zymotic diseases are essentially preventable, and that the salubrity of a place is to be judged of rather by its zymotic than by its general death-rate. More extended observations only can show which of the two sections of observers is nearest to the truth, viz., that which considers zymotic diseases (small-pox excepted) to be less amenable to sanitary measures than any other diseases, or that which classes zymotic diseases amongst the "preventable" causes of death. It fortunately makes very little difference in practice which theory is adhered to, as both parties concur in the belief that proper sanitary measures can reduce death-rates and prevent a large amount of unnecessary illness, and that the spreading of zymotic diseases can be controlled to a great extent by isolation of the sick.— *San. Record.*

HINTS FOR SURGICAL WARD CLERKS.

(*Continued from page* 71.)

A few points of surgical anatomy which are continually cropping up in reports may here with advantage be alluded to, as it is absolutely necessary for the ward clerk to be quite familiar with them. The measurement of limbs will frequently be necessary, and the correct points to be selected for this purpose should be known. In the upper extremity take the junction of the acromion and the scapular spine. There is here a natural angle almost always distinctly to be felt. In the lower limb your superior point will be the anterior superior spine of the ilium, always well marked even in corpulent persons. Below, your line will terminate at the inner malleolus. Some care is required to make this measurement satisfactorily. The patient must be quite flat and straight in bed, and the pelvis must not be tilted either one way or the other. It is always well to mark the extremities of your line with ink before taking your measurement, as this ensures much greater accuracy. Whilst upon the subject of mensuration, two lines, frequently spoken of in connection with the hip, may with advantage be alluded to. One, known as Nélaton's, is drawn from the anterior superior iliac spine to the most prominent part of the tuberosity of the ischium. In all positions of the limb it should just skirt the upper border of the great trochanter. Always take this line in cases of injury to the hip, of whatever kind, as any abnormal position of the trochanter is by it at once made evident. Another test line of much utility was originally suggested by Mr. Bryant and bears his name. It is constructed in this manner:—Connect the anterior superior iliac spines by a zonary line passing over the sacral promontory. From the lip of the great trochanter on each side draw a perpendicular to this. By comparing the length of this perpendicular any shortening of the cervix femoris, and consequent alteration in the position of the trochanter on the injured side, will be easily perceived. The zonary line from the sacral promontory to the spines may also be made use of to detect tilting of the pelvis. By carefully drawing such a line and comparing its segments from behind, the smallest deviation from the normal plane will be perceptible. Anatomical points could be dealt with *usque ad nauseam*, but it would be beyond my province to proceed further in that direction, and I shall conclude this paper with brief descriptions of a few of the principal mechanical appliances in use in the wards, with a view of enabling the junior student, for whom I am writing, to recognise each. Splints for the lower extremity are those which most frequently come under the reporter's notice. In describing the ordinary ones, their position as posterior, outside, inside, as the case may be, should be mentioned as well as the presncee or absence of a foot piece. A few special splints must be described by their names. A double splint used in hip-joint disease, or fracture of the cervix femoris, and extending on each side from the axilla to some inches beyond the feet, and secured to each limb, bears the name of Mr. Bryant. For some inches over the hip the wood of thesplint ceases, and is replaced by two projecting bars of metal, forming what is known as an "interruption." A "stirrup" of wood and strapping fixed to the affected limb, andconnected by means of a cord with a length of indiarubber, known as an "accumulator," on the outside of the splint enables extension to be applied. A simple straight wooden splint, used for fractured femur, and extending from the axilla downwards, is known as a "long Liston." Another splint in which a fractured femur is now

usually put up is "Hodgen's." The limb is slung in a sort of hammock of flannel and iron wire, extending from the upper part of the thigh to beyond the foot, and suspended by two cords, fitted with pulleys, to an upright at the foot of the bed. A straight splint in use in Pott's fracture (of the lower end of the fibula with dislocation) is usually called Desault's. MacIntyre's is a posterior splint with moveable foot piece, used for fractures of the leg. When your fracture patient goes out he will probably be provided with a "Bavarian" splint. This is an immoveable casing composed of two coats of flannel with an intermediate layer of gum and chalk. This splint, as it usually closes cases, will also close my remarks. I have reached the limits I had set myself, to put the junior student in some degree *au fait* with the slang of the wards, and to direct his attention to some of the many modes open to him of gaining information in this, I venture to say, one of the most valuable of our hospital appointments.

EXAMINATION NEWS.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

EXAMINATION FOR DIPLOMA IN DENTAL SURGERY.
DENTAL ANATOMY AND PHYSIOLOGY AND DENTAL SURGERY.
June 22, 1877.

DENTAL ANATOMY AND PHYSIOLOGY.

1.—Describe specimens 1, 2, and 3 under the microscope.

2.—Sketch the history of the developement of, and changes in, the Osseous and Dental portions of the inferior Maxilla from the period of birth to the age of seven years.

3.—Give the chemical composition of Enamel, Cememtum, and Dentine. Describe the chemical changes which occur in the latter during the progress of Caries, and state how they are probably effected.

DENTAL SURGERY AND PATHOLOGY.

1.—Enumerate all the circumstances under which the extraction of sound temporary and permanent Teeth may be necessary.

2.—What are the conditions of the Pulp which would induce you to endeavour to preserve or destroy it? Describe the treatment in both cases.

3.—Describe the form and structure of (*a*) Syphilitic Teeth, and (*b*) Teeth with rocky or honey-combed enamel, pointing out the distinctions between the two.

EXAMINATION QUESTIONS.

FINAL L.S.A., JUNE, 7th, 1877.

MEDICINE.

1.—Describe the symptoms of a case of Erysipelas; the different varieties; and your method of treatment.

2.—Describe a case of Hemiplegia, the different forms, its complications.

3.—Give the symptoms of a case of Aneurism of the arch of the aorta.

THERAPEUTICS.

1.—Classify tonics, give reasons for preferring any one class.

MIDWIFERY.

1.—Give the causes of inert labour, and your methods of treatment.

2.—The reasons for turning, and the various methods of doing it.

3.—Give the symptoms of Amenorrhœa, with treatment.

PATHOLOGY.

1.—Describe the method of making a post-mortem examination, including that of the brain and spinal cord.

MEDICAL JURISPRUDENCE.

1.—Give the tests for finding the presence of Arsenic and Antimony in an organic liquid.

2.—Symptoms of poisoning by Belladonna, Stramonium, and Œnanthe crocata.

3.—Give the more common feigned diseases, and your methods of detecting them.

BALSAM OF PERU AS A DRESSING FOR WOUNDS.

The treatment of lacerated wounds has always been tedious, and the results various, in general unsatisfactory; the wound has healed after a time, but often there has been a good deal of sloughing with consequent loss of skin. In the case of lacerated wounds about the hands and feet, not only is deformity to be looked for, but impairment of movement through loss of skin, adhesions of tendons, &c., is not an uncommon sequel; a local brawny infiltation, in inflammation of neighbouring lymphatics, and even abscesses, the result of lymphatic absorption, are occasionally seen, and are due to the putrid condition which the wounds often assume. In this class of cases, as well as in cases of compound fracture of the phalanges, it has been the custom in the surgery to use Friar's Balsam (Tr. Benzoin Co.) at once to seal up the wounds with, and the results have been good. Some months ago an account was given in some of the medical papers of a new method of treating such cases by sealing them up with Balsam of Peru. Last month Mr. W. P. Reynolds, then junior house-surgeon, determined to make a trial of this balsam, and he accordingly applied it in a number of cases, twenty-one in all. This number was made up chiefly of lacerated wounds of the fingers and toes, and included also several severe lacerated cuts about the wrist. All the cases did well, many of them were only dressed once, some of the severer ones required two or three dressings. The Balsam of Peru was freely applied to the wound, in which no sutures were ever inserted, and lint and bandage carefully put on; in the simplest cases the wound healed by primary union, and one dressing was sufficient. With larger wounds it was found that the dressing could be left on for four days without any bad result in the way of fœtor. In one bad case, where the lacerated wound extended across the wrist and along the dorsal surface of the thumb, the balsam was freely applied, without the introduction of any sutures, and four days afterwards the wound had healed by primary union. No suitable case of compound fracture for treatment in this way presented itself, but the balsam is doubtless worthy of a trial in such cases. Mr. Brett is this month making a further and more extended trial of this method, and the results shall appear in our next number.

GUY'S HOSPITAL GAZETTE, *JULY*, 1877.

A GOOD nurse is indispensable in every case of illness, and the more severe the illness the more necessary is the nurse. Looking at it from the patient's point of view, this is self evident, but it is also true that the Physician or Surgeon depends a great deal on the one who is in constant attendance on his patient, that is on the nurse.

It is from the nurse that he gets the minutiæ often so valuable, as to the amount of sleep during the night, as to the state of the appetite, as to the condition of the bowels, as to the general condition of his patient, whether there has been much restlessness, and a host of other details not worth much in themselves individually perhaps, but when taken together affording very valuable indications.

During his visit he is able to judge of the then condition of the case, but if at the same time, he can get a true account of what has happened since his last visit, and so obtain links in the chain of evidence, he is more likely to arrive at a true estimate of the state of the case. This is briefly then the function of the nurse in relation to the medical man, and it is no light duty.

To perform it satisfactorily, the nurse should possess *observation* and *intelligence*, observation to note all and the slightest changes, and intelligence to associate them logically in her mind. As an example of what we mean by "logical association," many nurses are able to distinguish between morbid subjective sensations, and pain due to definite lesion. A patient sometimes complains of being in fearful agony all night, in the morning there is no evidence to the doctor's mind, an appeal to the nurse in such a case often settles the matter. Observation on the other hand is very much developed by training and experience, and intelligence is fostered by it.

The duties of a nurse in relation to a patient vary with each case, hence we cannot go into them in this article, but a great part of them is included in making the patient *comfortable* both in body and mind. This sounds ridiculously easy, but it is not easy when a body is saturated with pain as in rheumatic fever, or when prolonged insomnia makes the sufferer restless and irritable.

Turning now to the Wards of this Hospital, what experience do we get there of nursing? and first we will confine our attention to the Surgical Wards. Here the dresser learns in a great measure how to nurse, during his nine months (three as Assistant Surgeon's dresser, and six as full dresser), he will probably have to dress cases of every variety, and no greater duty has he, we firmly believe, than that of leaving each case as comfortable as circumstances will admit, and in the best position for physiological *rest*. With the splendid surgical appliances of the present day, this is, in many cases, not difficult, but strange cases are always occurring, abscesses and tumours will often occupy the most awkward places, and these test his ingenuity and nursing skill. He should not be above arranging pillows and cushions, not only because the public will demand it from him afterwards, but also because humanity and repair both alike call out for rest. Owing to our method of Clinical work at Guy's, our nurses occupy a somewhat anomalous position; until very recently indeed, it was the commonest thing for the dressers on entering the ward in the morning to see the nurse on her knees scrubbing the floors, and it seemed unreasonable to call her away from the soap-suds to assist in dressing some case, now we are glad to say there are to be regular paid scrubbers. But the nurses have other duties to perform, and as everything seems to be done in the morning, the dresser, if he has a lot of cases, has usually very much of a scramble to finish dressing by dinner time, half-past twelve. In some wards the sisters prepare the dressings for each case before hand, and it is a great comfort to find lint, strapping, gauze, &c., all ready, for by this much time is saved, it is an excellent plan and works well in other hospitals. We hope to see it generally adopted in our wards, especially now that the hue-and-cry of "economy" has been raised, and dressings are doled out with a sparing hand.

The remarks made above as to the duties of nurses

refer chiefly to private cases; in hospitals the clinical clerks and dressers do a great part of the observation, but they also depend for information as to the evening and night on the nurses and sisters. Of course we do not expect in every case the luxury of a skilled and intelligent nurse, but the contrasts in the wards are sometimes very vivid. We remember on one ocacsion an operation had to be performed in the middle of the night, and the sole nurse in attendance had never been present at an operation in her life, and had not the remotest idea what to get ready; such an occurrence happily is very rare. We believe the system of nursing in this Hospital is now undergoing revision, and that a new system will shortly be started.

NOTES OF THE MONTH.

FINAL EXAMINATION FOR THE FELLOWSHIP, COLLEGE OF SURGEONS. At the recent examination, the following Guy's men were successful:—Mr. T. D. Harries, and Mr. John Rendall.

SENIOR APPOINTMENTS. Messrs. W. A. Kidd, M.B., B.S. (House Physician), and Montagu Lubbock, L.R.C.P. (House Surgeon), retire from office, and the vacancies have been filled up as follows:—

House Surgeons.—Mr. Brett (July), Mr. J. Mackern (September), Mr. A. Barrs (November).

House Physicians.—Mr. W. P. Reynolds, Mr. A. G. Lacey, Mr. C. W. Lacey.

EXAMINATION FOR THE L.D.S., COLLEGE OF SURGEONS. Mr. Pedley, M.R.C.S. has passed the above.

PRESENTATION OF MEMORIAL TO THE TREASURER. A memorial, signed by the Dressers and Clinical Assistants, and praying for a continuation of their late priveleges in the matter of prescribing for their cases in the wards, has been presented to the Treasurer of the Hospital. The matter being under consideration at the time of going to press, we must defer notice of it till our August number. At the same time we sympathise with the Dressers and Clinicals, in their struggle for liberty, and wish them every success.

Mr. COCK ON PRIMARY SYPHILITIC SORES. In the *Guy's Reports* for the present year, Mr. Cock draws attention to the position of primary sores as influencing their condition and appearance. He begins by saying that any part of the penis, from the base to the apex, may become the subject of a venereal sore, though they are most frequent in the extremity of the organ. Simple sores, and those which have inbibed the syphilitic poison, resemble each other so closely in their early stage, that it is very difficult, frequently impossible, to distinguish between them. The solid effusion causing the induration so characteristic of a true syphilitic sore, may be early or late in its appearance, and the amount and extent of induration, has been said to indicate and foretell the extent and severity of the "Secondary symptoms."

Mr. Cock believes that there is much fallacy in this opinion, and goes on to say, "My experience would show that the extent of the induration connected with a syphilitic sore, and the amount of its density, is governed much more by its situation and the textures involved, than by the virulence of the inoculated poison." He then details the structure of different parts of the penis, and lays down the rule that "the more cellular membrane, the more solid deposit," and this, "is well exemplified in those sores which so frequently occur in the coronal groove, involving at once the root of the prepuce, and the base of the glans. There is abundance of solid effusion on the former, but little or none on the latter," Finally he sums up his original paper with the following propositions:—

1.—Marginal sores, which frequently occur along the extreme edge of the prepuce, although decidedly specific in their character, are seldom or never productive of severe "Secondaries."

2.—Syphilitic sores, affecting the internal or external prepuce may be considered more serious in proportion as their position is further removed from the preputical margin, and nearer to the base of the glans, and main body of the penis.

3.—Sores occurring on the body of the penis are more formidable than the two previous classes, and I have reason to believe, that the nearer they are to the pubes the more may be apprehended.

4.—Sores on the glans, more especially when situated at its base, involving the coronal groove, and corresponding portion of the root of the prepuce, are most to be dreaded. They are almost inevitably, even in spite of early treatment, followed by widely-diffused and long continued constitutional symptoms, frequently baffling the skill of the Surgeon, and wearing out the patience of the sufferer.

5.—Sores contracted at the frenum become more or less important according to their extent. When they destroy the entire fold of the frenum, and involve its attachment to the glans and prepuce, they may be classed as sores of the coronal groove.

LIEBRICH ON CHLORAL. Probably no drug is more fashionable or more indiscriminately used in the present day than Chloral; yet increased experience of its use does not seem to have led to a uniform opinion as to its benefits; it does not always quiet the restless patient, and produce the refreshing sleep which is said to resemble most of all, "natural sleep." Of course, in many cases, the drug has been used injudiciously, perhaps the most common mistake made, is to expect hypnotic effects when the sleeplessness is associated with pain, or where there is peripheral irritation of Sensory Nerves. But in other cases it is not so, and Dr. Oscar Liebrich shows in his paper, how the negative, and sometimes positively evil effects of Chloral are due to impurities in the drug. He says, "The accidents which have occurred frequently in England, are, I am satisfied, largely due to the impurities and uncertainty of the many preparations, and especially of many of the solutions in vogue." The method described in our text book of Materia Medica does not produce pure Chloral, and Chloral Hydrate occurring in needles, is quite unworthy of confidence." When Chloral is found to be unduly acid, it is due to the presence of Chloro-Carbonic Acid which sets free H.Cl, and it is further proved that when this liberation takes place in the blood, it gives rise to great constitutional excitement. Cases then of nervous irritation, following the use of Chloral are due to the presence of Chloro-Carbonic Acid as an impurity in the Chloral. But Liebrich has also known cases where perfectly pure Chloral produced excitement, and this result he ascribes to an imperfectly alkaline condition of the blood. In Typhoid fever, where Dr. Russell has observed the blood to be excessively alkaline, Chloral has an extraordinary effect, and should be given only in very small doses during the stages of excitement and delirium. Ten grains are often enough in Typhoid, while in Delirium Tremous, one or two drachms are necessary. In Uric arthritis the drug may produce great excitement, and after full doses of alkaline, a good hypnotic effect was obtained. Chloral Hydrate poisons

by paralysing the heart, retarding the pulse and respiration, hence Liebrich urges the use of Strychnia in such cases as an antidote.

Pure Chloral Hydrate produces rest and relieves pain without excitement, nausea, or gastric irritation, and increasing doses are not necessary.

Impure Chloral, irritates the stomach, produces excitement, headache, and sickness. The best effects of Chloral are not produced on an empty stomach.—(*Practitioner*, June.)

BINZ ON THE MODE OF ACTION OF NARCOTICS.—The last quarterly number of the *Archiv fur Exper. Pathol. und Pharmacop.* contains an article on this subject by Dr. Binz. Funke long ago affirmed that brain substance in a state of rest was alkaline, but acid after a period of activity. Durham regarded this acid condition has hindering the oxidation upon which the function of the brain depended. Heynsius, on the other hand, looked upon it as retarding the transudation of albumen into the brain-substance. Of more recent date is Preyer's theory, that sleep is due to a tiring of the brain through an accumulation in it of the products of tissue-waste, which seize upon the oxygen destined for the brain, and thus render it unable to perform its function. But relying on the changes produced by the action of morphia, chloral, ether, and chloroform on fresh pieces of living brain—coagulating and darkening the intercellular substance; and taking into consideration the properties possessed by quinine and other allied alkaloids, of entering into a kind of temporary combination with certain forms of protoplasm, and thereby diminishing its oxidizing power, Binz supposes that these bodies possess strong affinities for the grey substance of the brain, and therefore enter into combination with it, and that, through the resulting alterations in its tissue-changes, it is unfitted to perform its function of wakefulness. Chloroform and ether form less stable combinations, and are, accordingly, more fleeting in their action than morphia or chloral. His experiments further show that sleep is not necessarily preceded by diminished blood-supply, but that this follows rather as the consequence, than as the cause, of the narcosis. Like other resting organs, the brain in a state of sleep contains less blood than in the active condition.—(*Med. Rec.*)

Mental Diseases.

By Dr. G. H. SAVAGE, OF BETHLEM HOSPITAL.

GENERAL PARALYSIS OF THE INSANE.

A general progressive paralysis of the same kind is seen in general hospitals and may have no mental symptoms, beyond mental weakness, and yet end fatally.

The disease we have to consider consists of (1) motor troubles; (2) mental weakness; (3) delirium, often of an exalted nature; (4) adhesions of the membranes, one constantly present.

There is generally a prodromal stage of variable length. The patient becomes changed in character and temper; he may be apathetic or irritable, give himself up to alcoholic or sexual excesses. In many cases little is noticed of this stage.

The disease may first manifest itself in motor or in mental troubles; the patient may lose consciousness, lose power in a limb, or show marked tremor of facial muscles. On the other hand he may be seized by vague dread, passing into melancholy, or he may at once feel unlike himself, powerful, wealthy and grand, and soon fix on some form of exalted ideas.

In this stage patients are restless, constantly on the move, always writing letters, talking volubly, composing histories or poems, drawing pictures, and doing everything in a self-satisfied confident way. Even at this period their memory begins to fail, one thought crowds out the preceding one. Sexual desire is strong in these cases; sometimes we see, in the early stages, marked anæsthesia for a time. The symptoms become more and more marked, and, when they have reached their highest point, weak-mindedness becomes more evident. Patients at this period squander their money, form improper relationships, and cause endless annoyance. This exaltation may only exhibit itself in a feeling of robust health, the tottering patient saying he was never so well in his life.

We see many other insane patients with exalted ideas, but, as a rule, they stick to one set of grand ideas, whereas a general paralytic is mobile, one moment an emperor, the next a pope, in one he runs the Derby winner, in the next communes with God.

The power of reason is damaged or lost from the first. The patient is very emotional and irritable, at first fond of decorating himself and collecting trifles, and, later, indecent, dirty, and untidy. He mixes the real and ideal, and has odd feelings about his identity. I saw one man who used to look for himself under his bed.

Sleepiness is another very common symptom, and I have seen a man fall asleep over his dinner or in a half finished tale of grandeur.

There may be hallucinations of the senses; God may be heard speaking, or enemies may be galvanising him.

Beside the above, we may have general paralysis coming on with melancholy symptoms, the prodromal stage becomes definitely a state of mental pain; this may become more and more profound, and the patient pass into a paralysed dement; or the melancholy stage, after lasting some months, may pass into a stage with exaltation and weak-mindedness.

Another form is that in which the patient slowly and steadily loses mental power, becomes weak and cowardly, without any evidence of delusions. There are two distinct varieties of this kind; the one slow and insidious, including many of the cases of general paralysis without mental symptoms; and another in which the dementia is rapid, the physical loss great, and the fatal end soon reached.

On the motor side we get (1) difficulty of articulation; (2) inequality of pupils; (3) uncertain gait. On the sensory, more or less anæsthesia. There is often a tremor of the lips before a word is said; the tremor varies much from hour to hour. There is often a slight catch in speaking, or, later, a stammer or elision of letters. The tongue trembles after it has been protruded a few seconds, and is commonly supported on the lower lip. These tremors are worse after any emotional disturbance, Some have a constant habit of swallowing, others of grinding their teeth.

The pupils are commonly irregular; at first they may be contracted, and later dilate unequally. Some cases, however, have contraction throughout. Strabismus and ptosis are rare. Sight is slowly impaired.

Patients walk freely for some time, then get to throw out one leg and let it fall heavily on the ground, they trip easily, and hesitate or totter on turning round. Loss of power about equal in upper and lower limbs, difficulty in buttoning shirt and coat.

The first stage thus described may vary much, but the second stage is alike in all.

Motor and intellectual troubles increase, there is more or less excitement, with paroxysms of violence, restlessness, talking to themselves, tearing up of clothes. The patients collect pockets full of rubbish and dirt, eat ravenously any filth, forget their friends, or cease to think of them when absent, they may still talk of millions without knowing what they say. The embarrassment of speech is greater, and, if they can be got to write, the writing is shaking and irregular; the grinding of the teeth is more frequent. Appetite large.

At this stage the patients commonly stumble and fall about, and may readily fracture an arm or leg as the bones are certainly more brittle than usual. They often get fat, and

have constantly a greasy skin. The temperature is not uniform, but usually is raised 1° to 2° at night. The patients may appear ataxic, and may exert great force when lying down.

In the third stage we get involuntary passage of urine and fæces, speech is gradually lost, walking is difficult or impossible, yet the muscles are rarely much wasted, I find they do not react readily to galvanic stimuli. In this vegetative state they may live for months, eating well and being well nourished. The end may be due to (1) congestion of the brain, coma, and death; or (2) exhaustion from inability to swallow; (3) to accident of diarrhœa, pneumonia, or cystitis; (4) or from suffocation, or choking.

General paralysis averages from one to two years. I have seen a few die in three months, and others live for six or eight years. Complete remissions may occur. I have never seen this happen twice in one case. The remission may last a few weeks, or even a year; the relapse, as a rule, rapidly ends fatally. Maniacal and excited cases more frequently have these remissions. I have never seen a case cured. Those reported as cured are almost certainly cases of alcoholismus.

One of the most characteristic symptoms of general paralysis is the congestive attacks, the epileptiform seizures; these may be at the outset, or occur in either of the other stages, and rapidly revive the patient's intellect; they are of various kinds varying from slight vertigo and apoplectic like fits. Marcé gives six varieties: 1.—The slight with agitation. 2.—The maniacal. 3.—The comatose. 4.—Hemiplegic. 5.—Convulsive apoplectic. 6.—Mixed and irregular. Any patient may have all the varieties at different periods. The more common resemble severe epileptic fits, but, as a rule, leave more local paralysis that is more slowly recovered from. Some resemble apoplexy, but a few days shows recovery of use of limbs incompatible with cross lesion of the brain. After the first fit the mental deterioration is marked, patients hitherto troublesome and irritable become silly and docile.

Another accident is hæmatoma auris that is not uncommon. An effusion of blood into the a uricle beneath the perichondrium, it is often symmetrical. It may occur from injury, and is seen in other chronic mental diseases.

As far as treatment goes, we can only palliate. Good diet and plenty of fresh air are the best. Physostigma has been praised, and I think I have seen 15 minim doses of the tincture given every 4 hours assist in bringing about remission. The patients should be kept out of bed as long as possible or bedsores will rapidly form. Water beds are necessary as the loss of power and contraction of limbs becomes developed.

As to the pathology, all we can do at present is to say what we find and not why it is. We get wasted brains, with adhesions of membranes to the cortex, especially, according to Foville and Browne, over the anterior and lower lobes about the fissures of Sylvius and Rolando; the membranes are thickened: there is excess of fluid, the arteries often atheromatous; there may be false membranes or layers of recent blood on dura mater.

Microscopically we find wasted nerve cells, cells undergoing fatty and granular changes, often excess of leucocytes, and kinked vessels; beside this we find corpora amylacea, and colloid changes have been described. The sympathetic of neck has been said to be degenerated and pigmented. I would add there is no characteristic state of optic disc or pulse tracing.

REVIEW.

Practical Histology. Dr. Thin. Balliére, Tindall & Cox, London.

The advances made in recent years in every department of medical science, are well exemplified in Histology, which perhaps has made the largest strides of all. This advance is due in the first place to the perfection of the achromatic microscope in the direction, not so much of magnifying power, as in definition and achromatism, whereby fibres and outlines can be more accurately described.

Another cause of progress too is accumulated experience in the methods of preparing the different tissues and organs; not many years ago the art of staining was scarcely known, consequently the distribution of nuclei and protoplasm was little understood. The introduction of staining by Nitrate of Silver by Recklinghausen, has led in a great measure to the wonderful mass of facts which we now possess with regard to the Lymphatic system, the merest tryo in Histology can now trace for himself the distribution of Endothelium and lymph spaces and canals, where a very few years ago, the best authorities did not know of their existence. In the same way the elaborate use of Carmine by Beale furnished him with the necessary facts for his theory of Bioplasm and Formed Materia?

In accordance with this advance, many text books have appeared, especially during the last year or two in this country, the colossal "Handbook for the Physiological Laboratory," was among the first, and some good less pretentious volumes, have since followed. Dr. Thin's work makes no pretensions to supersede any of its predecessors (and he dont think it will).

The book consists in a great measure of descriptions of most of the methods of staining and chemical treatment of tissues which have been very recently introduced; examples of the uses of Picric Acid, Osmic Acid, Chloride of Palladium Purpurine, and the different Aniline compounds are given. The greatest novelty perhaps is the author's "Saturated Potash Solution," which is a solution of *caustic* potash in an equal weight of distilled water; necessary conditions of success are chemical purity of the potash, its perfect dryness and a certain temperature (first heat to 130° or 140° F. and when it falls to 107°, put the tissue in). Dr. Thin says he has found special results by using this solution; on looking through the book we find the chief result has been the discovery of "narrow elongated cells," anywhere and everywhere. A number of narrow elongated cells were isolated from the mesentery of the frog by saturated potash solution (p. 50). In exceptionally successful potash preparations there can be seen fine, narrow elongated cells lying parallel to the nerve fibre (p. 89). In the case of the fibres of frogs muscle, the potash brings to light one or two central canals, and after prolonged treatment with this tender solution, oval, clean-cut holes are seen in the Sarcolemma, and it is through these holes that nerve fibrils probably pass into the interior of the fibre, they also allow a free passage for lymph (p. 76). But it is in treating of the Cornea that the author fairly revels in potash, and a drawing of a narrow elongated corneal cell is given on p. 116. These and "other cells of the size and form of ordinary endothelium separated or joined in groups," have already appeared before the Royal Society, so that it is not necessary for us to say anything about them. In the paraphraphs on Cartilage (p. 60), very important results have been obtained by potash, only success is very exceptional. In one instance also, we may note minute narrow elongated cells turned up (p. 61), but we think Dr. Thin is enthusiastic when he keeps serum fresh preparations of Cartilage for 7 months, and then finds "giant cells" in the preparation.

In conclusion, we do not recommend the book to students *commencing* the study of histology, not only because it is too sketchy, but also because there is so much in it *sui generis* that it is better fitted for maturer judgments. Those who are interested in practical histology will find plenty of suggestions, more or less original, scattered through the book, and all will find the paragraphs of Connective Tissue, Bone, Retina, and the Section on Embryology, translated from Dr. Exner's book, well treated and instructive.

We have received the following subscriptions:—N. Montifiore, Esq., 10/0; Dr. English, 9/2; R. M. Simon. Esq., 8/0; Edwin Duke, Esq., 5/6; A. H. Jones, Esq., 2/9.

Correspondence.

MONSON HILLS' FUND.

TO THE EDITOR.

SIR

Can any of your numerous readers inform me what has become of the money that has been raised for Monson Hills? In December last a circular was sent to me stating that a fund was being raised for Monson Hills, who had just been pensioned off from Guy's, and asking me to subscribe. I forwarded my donation, but the receipt of it has never been acknowledged, nor have I heard from that time to this what has become of, or what is being done with, the money.

Believe me, SIR,
Yours faithfully,
June 18th. W. H. JALLAND.

NOTES FROM THE WARDS.

CASES UNDER THE CARE OF Mr. COOPER FORSTER.

June, 1877.

LUKE.—1. A boy admitted with a fluctuating swelling in the left buttock. The fluid evidently deeply seated beneath the gluteus maximus. There was impaired movement of the hip-joint. The femur could not be fully flexed, the pelvis moving with it in extreme flexion. There was also some lameness, but no pain about the joint and no marked deformity. Abscess opened antiseptically, a deep sinus runs downwards towards the back of the joint.

LUKE.—7. A man with a small sinus in the left lumbar region which was excised for three years, commencing as an abscess, which burst and left an opening which has several times closed, pus has again collected and the sinus reopened. It discharges a thin albuminous fluid containing neither urea, uric acid, nor phosphates in any characteristic amount. The sinus runs deeply upwards and inwards towards the kidney. There is pus in the patient's urine, and increasing in quantity when the sinus does not discharge. Sp. gr. 1012. Acid. The sinus was cauterised by galvanic cautery and was crusted over. General health good.

LUKE.—8. A man of 22. Suffered from Acute Rheumatism 7 months ago, at which time his knees were allowed to become flexed, they have remained so and an osteo-arthritic condition has been set up (Polyarticular chronic rheumatism of Bilbroth?) There is slight displacement of the right tibia. The left knee has been forcibly straightened under chloroform; the right, perhaps on account of the displacement, resisted forcible extension. There is also some stiffness of the left hip, which complicates the treatment, for the patient cannot balance himself on the left leg which has been straightened. If he succeeds in supporting himself on the one leg, the further treatment consists either in excising the right knee, or in leaving him to get about with crutches on his one straight leg.

LUKE.—9. A case of old fracture of tibia, which, after union had taken place, gave way in consequence of the patient resting his weight upon it too soon. Bending of the leg took place, and subsequently necrosis of tibia around seat of injury. The original fracture took place 18 years ago. Some dead bone has been removed, other exposed bone is granulating. Lardaceous viscera.

LUKE.—11. Calculus vesciæa, Lithotrity, Oxalate of lime phosphate, and uric acid combined. An interment attack of diphtheritic (?) sore throat has come on.

LUKE.—12. Amputation of penis for epithelioma. The operation was done with the knife, the urethra and corpus spongiosum being cut longer than the corpus cavernosum in order to facilitate the passage of urine in a stream. Congenital phimosis existed.

LUKE.—14. Boy æt. 2. Admitted with some of the symptoms of hip-joint disease and slight peritonitis (?) The thigh being flexed upon the abdomen, chloroform was given and the thigh straightened, acute peritonitis followed, and the weights used for extension were obliged to be removed, on subsidence of peritonitis extension was again made under chloroform, and adhesions within the abdomen, in the iliac fossa were distinctly felt to break down; great œdema of thigh and lower part of abdomen followed, and probably there is deep suppuration. Diagnosis doubtful as to source of mischief, whether hip, spinal or pelvic.

CHARITY.—2. Caries and Necrosis of Tibia, treated by application of strong sulphuric acid. The progress of the disease was stopped and the part healed to a certain extent, but lardaceous disease of the viscera has appeared.

Cot 27. Caries of tarsus, external and middle cuneiform bones removed, much improvement.

CHARITY.—3. Girl æt. 11. Abscess deeply placed in pectoral region and great thickening around it, the abscess has been opened but the thickening does not subside so rapidly as it should in an uncomplicated case. Diagnosis doubtful, possibly diseased bone, caries or necrosis of rib, possibly malignant growth of bone, possibly merely subpectoral abscess.

CHARITY.—7. Pott's fracture, treated by outside splint.

CHARITY.—10. Dysphagia following alleged swallowing of Sulphuric Acid. Query cicatricial stricture of Œsophagus. Query Hysteria.

CHARITY.—13. Old ulcer of leg, Cicatrices from Erysipelas, Immobility of ankle joint and mal-position of foot. This patient has come in to have amputation performed, on account of pain and uselessness of the limb. She has been in the hospital before and the ulcers did not yield to treatment.

CHARITY.—17. Lumbar abscess, dependent upon angular curvature of spine of many years standing, treated by hyperdistension of the abscess sac with carbolic acid and antiseptic dressings. The abscess was on the point of bursting on her admission on May 20th. A small opening was made into it, eleven ounces of pus were removed and twelve ounces of carbolic acid (iv. 40) injected, with a pewter syringe, a drainage tube was then put in, the lotion having been let out after remaining in the sac for a few minutes; since that time no pus has been discharged, but only a small quantity of serum at each dressing.

CORNELIUS.—3. A case of severe concussion of the brain, from a fall upon the head out of a cart. No localised injury. No paralysis. An epileptic fit followed half an hour after injury, and partial insensibility, followed by a semi-comatose condition lasting ten days. He is now recovering. Treatment consisted in perfect quiet in bed and a dose of calomel gr. X, put upon the back of the tongue.

CORNELIUS.—4. Patient fell astride of a wooden paling. Immediately after the injury he passed blood, per urethram. Passed no urine until admission, twenty four hours after accident. A small French catheter was passed and fastened into the bladder. Two perineal abscesses formed and were opened, through one of them an extensive opening into the urethra was felt. An attack of epididymitis from direct extension of inflammation followed. Catheters of gradually increasing size have been kept in, and the perineal wound is now nearly closed.

CORNELIUS.—9. A case of fractured base of skull (anterior fossa) from a fall upon the vertex from a van. Insensibility. Facial paralysis on left side. Protrusion of left eyeball and subconjunctival ecchymosis with bleeding from nose. No paralysis of limbs. No localised injury. For some time the patient remained insensible, but very restless, he is now partially sensible, the ecchymosis is disappearing, and the protrusion of the eyeball is less marked. Treatment, quiet in bed and calomel.

CORNELIUS.—12. Pott's fracture, treated by a back and

two side splints, with pads making pressure upon the shaft of the Tibia.

CORNELIUS.—18. A boy admitted for fractured thigh. He has an annual attack of Psoriasis, coming on in the spring and lasting for several months, and then spontaneously disappearing. He is now treated with Ung. Pulv. Goa applied to portions of the skin, it has apparently had some slight effect upon the eruption.

CASES UNDER Dr. MOXON. June, 1877.

PHILIP.—3. Right Hemiplegia with Aphasia. A good case from which to get into one's mind that Aphasia does *not* mean paralysis of any of the muscles used in vocalization. The patient can say *yes* and *no*, and generally uses these words correctly. It is worth noting that he seems quite satisfied with all his remarks, and not conscious that he is talking nonsense. No cardiac disease.

PHILIP.—6. Fusiform dilatation of the Aorta in a strong powerfully built man, a stonemason, who has been accustomed to move and lift heavy weights. The heart is enormously enlarged, the impulse very diffused and hearing and can be seen over a large area, far to the left and below the nipple. Both systolic and diastolic aortic murmurs to be heard, pulse at the radial very good example of the *splashing aortic* pulse, and not only the radial but the ulnar and both the anterior and posterior Tibials can be plainly seen pulsating beneath the skin. Has never had Rheumatism.

BRIGHT.—12. A well-marked example of that form of leucocythemia in which the spleen is very much enlarged, the liver is also enlarged, but much less so than the spleen, and no increase in size of the lymphatic glands to be anywhere detected. This case also bears out the statement made by Dr. Wilks, we believe, that such patients do not look so anæmic. Under the microscope the leucocytes far outnumber the red.

HYSTERIA.

Second Prize Paper read by Mr. P. HORROCKS before the Physical Society Oct., 21st, 1876.

The derivation of the word Hysteria, implies that it is an affection to which women alone are liable; this results from the fact that at the time the disease was named, it was only observed in women, and was, generally, due to some uterine disorder. But when years afterwards symptoms were observed in men, not be distinguished from, but identical with those of Hysteria, the same term was used, though etymologically it is absurd to apply it to men.

Now the term Hysteria has fallen into such repute, that, with the general public, it is almost synonymous with silliness, hypocrisy and deceit. So that a person feels indignant if you call her hysterical.

A girl in Bright Ward who had hysterical vomiting for three months, and who had been a nurse at the Westminster Hospital, was very indignant because I asked her if she ever experienced a sensation of choking she chanced to know that it was a symptom of Hysteria and so saw of what I was thinking. She repudiated the idea, and said if she thought she was imposing on people she would work her fingers to the bone, before she would complain. I tried to assure her that being hysterical did not mean imposing on people; but she would have none of it. Hysterical patients are not malingerers in the majority of cases, many exaggerate their symptoms, and true malingerers may simulate Hysteria; but Hysteria does not mean shamming.

From its unhappy derivation and its popular disrepute, Sir James Paget wishes to discard the term altogether, except perhaps for certain cases which simulate no disease nor are themselves simulated, and proposes the term "Neuromimesis" instead. Amongst the profession Hysteria answers every purpose, as we know to what it refers, and the objection of its derivation would apply equally to many diseases known by old names. But seeing that it has had its meaning perverted in this way, perhaps it would be as well to adopt some other term before your patient, such as "Neuromimesis," or "Neurosis," to have which she would be proud rather than ashamed. You know there is pride even in one's ailment. Have you never heard the patients telling one another what accidents they have had, comparing notes, &c.? I once heard two women in Dorcas Ward, having high words, the point in dispute being which had the worst leg before operation. What I wish to point out, is, that whether you discard the term Hysteria or not amongst yourselves, don't use it before your patient, and if she wants to know from what she is suffering tell her "Neuromimesis" or "Neurosis," or use some such term which will satisfy her and enable you to prosecute your enquiries, having the benefit of her entire confidence in you and your treatment.

If the importance of a disease is gauged by the frequency with which one meets it in practice, Hysteria must be placed amongst the most important; if by its fatality, amongst the least so. But seeing that every disease may be simulated by it; that it constitutes four-fifths of joint affections amongst the upper classes according to Brodie; that it is so frequently met with in one form or another; and I hope to show you it is more frequent in men, even than is commonly supposed; and that its treatment is very different as a rule from that of the affection it may simulate, I take it, that we must look upon it as a disease to be carefully studied and by no means overlooked.

Practically acquainted though I am with the fact that the requirements of the various examining boards, and the infinity of the subjects that are included within the scope of our profession, compel us as students, to leave out altogether or to pass over superficially many things, to which, when we enter into practice we may find time to devote more attention, yet, I look upon Hysteria as one of those diseases which it behoves every medical man even in statu pupillari, to study and to become thoroughly acquainted with, in its various forms. Of this I am certain. You cannot walk the wards of this Hospital without seeing a great many examples of it. When I was asked to write a paper for this Society I chose Hysteria because I had seen more of it than of any other disease. A knowledge of it will not only enable us to apply the treat-

ment proper to it, but will prevent us from falling into the error of treating such affections as organic, whereby we put the patients' friends in needless fear, perpetuate the disease by concentrating his or her attention to the malady, and employ remedies which if not injurious are at least useless.

"Treat all things innocent until proved guilty," would not be a bad maxim to work upon. Dr. Braxton Hicks tells us when sent for to a woman in labour, to assume she is not pregnant until this is proved, and then assume she is not in labour until this also is made certain, and gives an instance of a medical man who sat by the bedside for several hours waiting for a pain, after which he discovered the woman was'nt even pregnant, much less in labour. So if you treat all cases as hysterieal which are not prima facie organic, you will be less liable to fall into error than if you go on the opposite tack.

At the present day the term Hysteria has a very wide acceptation. As our knowledge has extended as the functions of the various systems have come to be more known, especially with regard to the relations of the nervous system to the rest of the body, we have discovered that functional disturbance of any part may so affect the nervous system as to lead to those train of symptoms which we call Hysteria.

In fact at the present day Hysteria may be defined as "A peculiar affection of the nervous system characterised by a perversion of the Will."

Dr. WILKS defines it as "An abeyance of the brain allowing the rest of the nervous system to be deranged," and compares the state to that of a pigeon with its head just cut off, whereby the spinal system is left to itself, without the governing influence of the will.

I just now made use of the expression "functional disturbance of a part," which is said often to be the cause of Hysteria. So far as I have been able to discover "functional disturbance" means disturbance due to some cause which at present is unknown, and which does not damage an organ in any way discoverable by us. But all so called functional disturbances are due to pathological changes, though we may not know what those changes are, and hence as we advance in knowledge, functional diseases diminish, because we find out their causes and so place them amongst organic diseases, the term is however convenient if you are not misled by it.

All examples of Hysteria may be set down as simulated organic disease, but in addition to the simulated symptoms we have others which are peculiar to Hysteria itself. These are chiefly emotional, such patients are easily excited, laugh and cry immediately and for little cause; are very fidgetty and restless, generally loquacious, talking about themselves; they may be subject to the globus or clavus hystericus, or to sudden eructations with loud rumblings and very often to palpitation. In well marked cases you can see at a glance that your patient is Hysterical.

Some writers have tried to separate the paroxysmal form of Hysteria from the rest, but inasmuch as the convulsive and the non-convulsive paroxysms have their double in the haut-mal and petit-mal of epilepsy respectively, I think all examples of Hysteria may be said to be neuromimetic.

Now it will be impossible for me in the short time at my disposal to go over the various forms of Hysteria, for in that case I should have to treat of every known disease. I must therefore content myself with dealing with the convulsive and the non-convulsive paroxysms, and deal generally with other cases.

These paroxysms are far more exclusively confined to women than the other forms of Hysteria; but there are authentic cases of true Hysterical fits in men, the forms which they may take are very varied. The patient often falls down struggles violently, exhibiting an astonishing amount of strength, inasmuch that it may take several men to hold down a weak girl, tosses her head and limbs about, snaps her teeth, or closes her jaws firmly, her breathing is hurried and difficult, and her heart palpitates. After this she becomes more quiet but in a state of such great nervous tension that the least disturbance sets her off again; and finally she bursts into tears or laughter, or both; after the fit she may pass a large quantity of pale urine. In the non-convulsive variety, the patient falls as if insensible, quite motionless, with slow breathing and congested face. She remains in this state for a variable length of time and then recovers, depressed in spirits and is very apt to cry and sob.

The above is a very short epitome of a paroxysm, but may serve to recall the nature of one to your mind, especially those who have not seen a case, for it must be needless to remind those who have once seen it can scarcely be forgotten.

Now I wish to call your attention to one or two features of importance in these fits. First of all such patients generally fall in a safe place, which in itself is suspicious of Hysteria though not conclusive; for epileptics sometimes have a warning of the oncoming fit, which you know by the name of the Aura. Secondly, they scarcely ever lose their consciousness entirely as epileptics do, and never at the beginning of a fit; and you must bear this fact in mind whilst talking in the hearing of your patient during an attack, indeed you may make use of it in your treatment. I know an instance of a young woman who was cured by its being said in her presence whilst she lay apparently unconscious, that she would never get married so long as she had fits, because nobody would have her! she never had any more fits.

During an Hysterical fit the pupils are sensitive to light and the temperature is generally normal. The cause of the paroxysm will always be found to be due to some slight cause either physical or mental, which will aid us in the diagnosis. Some of these patients seem as if they could work themselves into a fit at will.

This form of Hysteria is that which is best known amongst the general public, many there are who look upon it as the only true form.

We now come to those cases simulating other diseases besides epilepsy, and I may here say that in these cases you may or may not have the paroxysm present, if you have or can get a history of a former Hysterical fit, it will aid you materially in your diagnosis. I cannot go into all these cases, but some of you may be surprised at the statement that any disease could be simulated; for you may say naturally, surely some diseases are so palpable that they couldn't deceive any sane person. If there be such I should be glad if he would mention any one disease which couldn't be simulated.

(To be continued.)

ON DUTY FOR JULY.

House-Physicians:—Mr. T. L. Porter, Mr. C. Pickering,
Junior House-Physician:—Mr. A. G. Lacey,
House-Surgeon:—Mr. W. P. Reynolds,
Junior House-Surgeon:—Mr. T. B. Brett,
Senior in Charity:—Mr. C. G. Lee.
Junior in Charity:—Mr. Judson.

RESIDENT DRESSERS.

July 4th, Mr. Manby (Mr. Howse).
„ 11th, Mr. Uhthoff (Mr. Forster).
„ 18th, Mr. Paddis n (Mr. Bryant).
„ 25th, Mr. Chubb (Mr. Durham).

STATISTICAL REPORT OF LYING-IN CHARITY FOR MAY, 1877.

Number of women attended			168
Recovered	166		
Died	2		
	168		
Single Births		167	
Dual		1	
		168	
Women attended in 1st confinement			28
„ „ 2nd „			29
„ „ 3rd „			11
„ „ 4th „			26
„ „ 5th „			16
„ „ 6th „			11
„ „ 7th „			11
„ „ 8th „			8
„ „ 9th „			13
„ „ 10th „			5
„ „ 11th „			3
„ „ 12th „			2
„ „ 13th „			3
„ „ 16th „			2
		168	
Children at full time.			
Males alive	84		
Males dead	1		
Females alive	80		166
Females dead	1		
Premature children, 6 and 7 months			
Males alive	1		
„ dead	1		3
Females alive	1		
„ dead	0		
Abortion			1
Total number of children			169
Alive	165		169
Dead	4		
Presentations.			
Vertex		165	
Face		1	
Breech		1	
Foot		1	
Neck		1	
		169	
Operations.			
Turning	1		
Forceps	1		
	2		

Externs attended.

Mr. F. B. J. Baldwin	47
Mr. George H. Dodson	42
Mr. H. J. Moxon	35
Mr. C. H. Haycroft	25
Mr. J. Alexander	9
Mr. Alfred Burton	6
Mr. Fredk. J. Fehrsen	4
	168

W. CULVER JAMES,
Junior in Charity.

The appointment of Medical Registrar and Surgical Registrar at this Hospital are vacant; duties to commence in October next.

The vacant Demonstratorships have been filled up as follows:
Demonstrators. Mr. Carrington, Mr. Symonds.
Assistant Demonstrator. Mr. A. H. Jones, M.B.

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Clerk.

Clerk's Offices, Russell Street, Bermondsey.
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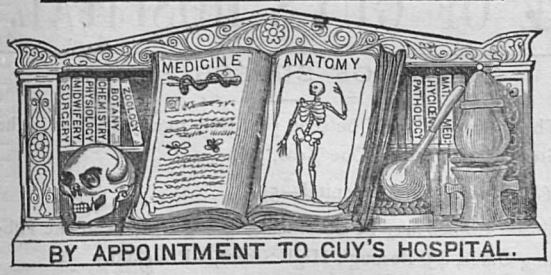

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Guy's	1.30 p.m.	1.30 p.m.	M. W. F. 1.30.	M. Th. 1.30 Tu. F., 12.	Tu. Th. F. 12
King's College ...	2 p.m.	1.30 p.m.	M. W. F., 1 p.m.	M. Th., S. 1	Tu. F., 10
London	1.30 and 2 p.m.	1.30 and 2 p.m.	...	W. S., 9	Tu., 9
Middlesex	1.30 p.m.	1 p.m.	M. W., 1.30	Tu. F., 8.30	Daily, 9
St. Bartholomew's	1.30 p.m.	1.30 p.m.	M. Th., 2 W. S., 9.	Tu. Th. S., 1.30.	Fr., 9
St. George's... ...	1 p.m.	1 p.m.	Th., 2.	W. S., 2	Tu. S., 9.30 Th., 1.30
St. Mary's	1.15 p.m.	1.15 p.m.	Fu. F., 9.30	M. Th. 1.30	W. S., 9.30
St. Thomas's ...	8.45 a.m.	8 a.m.	W. F. 12.30	Daily, 2, ex. S.	Tu. F., 10
University College	1.15 and 2.30 p.m.	1.30 and 2 p.m.	Daily, 1.30 ex. W. & S.	M. W. F., 2	W., 10.30
Westminster ...	1.30 p.m.	1.30 p.m.	Tu. F., 3.	M. Th., 3	W. S., 9·15

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Clinical Medicine.

By Dr. TAYLOR.

HEMIPLEGIA.

N. S., æt. 80, was admitted into Clinical April 18th, 1877. Family history good.

Previous history.—Had "inflammation of the kidneys" nine years ago, for which he kept his bed seven weeks. Never had rheumatism nor gout. No history of venereal disease.

History of present illness.—Was quite well five weeks ago, when one evening he noticed his speech getting thick and his mouth drawn towards the left side; he also noticed weakness about right leg, but he never lost consciousness. Next day he lost more power over his right arm and leg, until he became paralysed on that side.

When admitted he was a tolerably healthy looking man with the usual symptoms of right facial paralysis and right hemiplegia. No heart disease. No albumen in urine. Optic discs normal. Radial pulse strong and full; arteries thickened.

In commenting on the case, Dr. Taylor remarked that the "inflammation of the kidneys" mentioned in the previous history may merely have been pain in the back (lumbago). The hemiplegia had a gradual development within twenty-four hours, commencing with difficulty of speech, but there was no very sudden attack and no loss of consciousness. The case is evidently one of paralysis of the right limbs and of the right side of the face.

There is an idea very general amongst younger students that the paralysis of the face is on the opposite side to that of the arm and leg. They have perhaps learnt that injury to one side of the head may paralyse the limbs on the opposite side, and they have explained that by what they know of the decussation of nerve fibres in the medulla oblongata; but the main fact they have picked up about the facial nerve is that it arises from a nucleus on the same side of the middle line, whence they would infer that a one-sided injury should paralyse the face on the same side, the limbs on the opposite side. But the facts are opposed to this: in the great majority of cases of cerebral paralysis the face and limbs are paralysed on the same side. What has been overlooked in the above reasoning is this, viz.:—that there are fibres decussating between the facial nerves and the central ganglia, as well as between the spinal nerves and the central ganglia; and, secondly, that the spinal nerves come off from nuclei on their own side of the middle line, just as much as the facial does from a nucleus on its own side. In other words, the anatomical relations of the facial nerve (and cranial nerves generally) are precisely the same as those of the spinal nerves. Each spinal nerve is connected with the anterior arm of the grey matter which forms its nucleus, and this again by decussating fibres with the central ganglia of the opposite side. Each cranial nerve is connected with its own special nucleus, and this again by fibres crossing the median raphé with the central ganglia of the opposite side. An injury to these central ganglia must then tend to produce disturbance of function in all the voluntary nerves of the opposite side. And this leads to another fact in hemiplegia as ordinarily seen. The muscles are paralysed in very different degrees: the arm almost completely, the leg less, the face least of all; in the face, the lower part is more affected than the upper. Other muscles of the body may not be affected at all, as, for instance, the intercostals, the abdominal muscles, and the muscles of the eye. When one analyses these facts, it appears that those muscles are most paralysed which are accustomed to act most independently of their fellows on the opposite side, and those are least paralysed, or not paralysed at all, which are constantly performing simultaneous or alternating movements.

The intercostal muscles and the muscles of the eye rarely, if ever, act independently; their action is concerted and simultaneous, and, as mentioned before, they are not paralysed in hemiplegia. It is not often, too, that one side of the face acts without the other, though it is quite possible to perform the actions of sneering and winking with one side only.

With the legs, though their action when most frequently used, as in walking, is both reflex and concerted, yet independent action is more readily and frequently performed than in the face.

The muscles of the arms, and especially the hands, are used more independently of one another than perhaps any others in the body; for there are many things that can be done by the right hand that cannot be done by the left, and *vice versâ*.

The theory which accords with and explains these facts is that the nuclei of those nerves which supply muscles accustomed to act with their fellows have a strong physiological connection by means of commissural fibres, which, in case of lesion on one side of the brain, would convey impulses from the uninjured hemisphere. Thus,—if the right brain is torn up by hæmorrhage, it transmits no impulses to the left spinal grey matter, but the left brain is active, and impulses may travel from it, at first in the usual course, to the right spinal nucleus, and then along the commissure to the left nucleus. In the case of independent action of the muscles, the commissure does not permit the passage of impulses.

The causes of hemiplegia are numerous. One may mention tumours, tubercular meningitis, softening from degenerative change in the vessels, and anæmia from sudden plugging of an artery. Hydatids sometimes give rise to hemiplegia; while hæmorrhage and injury, leading to intra-cranial pressure, may mechanically interfere with the functions of the brain. A purely functional hemiplegia is also occasionally met with.

The great bulk of cases arise from these causes:—hæmorrhage, from rupture of a bloodvessel; softening, from diseased bloodvessels and sudden bloodlessness; and consequent softening from embolism.

Hæmorrhage occurs from disease of the vessels in most cases. Hypertrophy of the heart seldom acts alone without a morbid condition of the vessels; but, when an artery degenerates, its wall becomes thickened, and its channel may be so narrowed that the tissues supplied by it become anæmic and undergo degeneration and softening; or, as another result of the thickening, the blood may clot in the vessel itself. A clot of fibrin may get carried from the valve of the heart into one of the smaller central vessels, plugging it, first causing anæmia of the brain supplied by it, and then the brain softens and degenerates.

Tumour may be suspected when there are symptoms of intracranial pressure, such as severe pain, vomiting, convulsions, and congestion or inflammation of the optic nerve; or, if with one or more of these symptoms, there is paralysis of several cranial nerves.

Embolism commonly results from disease of the heart, since fibrinous clots are very apt to form on diseased valves and in dilated cavities. If the heart does not reveal any morbid changes, look at his other vessels; see if his radial artery is atheromatous.

Patients dying of apoplexy are frequently found to have granular kidneys and hypertrophied hearts. Examine his urine for albumen, and his retina for retinitis, retinal hæmorrhage, and brilliant white spots of degeneration. But the majority of cases present nothing abnormal beyond hard arteries, and these it is impossible to distinguish between softening and hæmorrhage from the local conditions alone.

Syphilis gives rise to disease of the artery walls, the cerebral arteries being especially liable to the inflammatory change; so that one may fairly enquire for a history of syphilis in hemiplegia.

In rupture of a vessel, the rupture may take place from an aneurismal dilatation of one of the cerebral arteries; the aneurism arising, as stated by some, from a previous plugging of the vessel by embolism.

The age of the patient may help the diagnosis. Degenerative changes, and the resulting softening and hæmorrhage, are most frequent after the age of 30; but fatal apoplexy has occurred much earlier. Embolism may happen at all ages, from childhood upwards; while the effects of syphilis would not be confined to advanced periods of life.

The manner of the origin of the attack should be carefully enquired into; did it commence with coma or without coma? The modes of development of hemiplegia are many. The patient may wake up after a night's rest and find himself hemiplegic, or the attack may come on suddenly; a shock is felt by the patient, he at once falls insensible to the ground, and, on recovering consciousness, he is found to be paralysed. Or the hemiplegia may first begin in the arm and face, and after these symptoms a state of unconsciousness may be gradually developed; or, as in this case, the hemiplegia may come on without any insensibility at all. If the patient becomes suddenly comatose, then it is very probable that he has an embolism.

Those cases which commence with slight symptoms of hemiplegia and then become profoundly comatose are very likely to be due to hæmorrhage; as the hæmorrhage increases the pressure would become greater.

A very gradually developed hemiplegia, of some days duration, would be most probably due to slowly spreading softening.

Both local and general conditions are, in this case, mainly of a negative character with regard to the diagnosis. He has atheromatous arteries, but no evidence of cardiac or renal disease. The hemiplegia developed rather slowly without loss of consciousness. One could not exclude with certainty either a moderate hæmorrhage or a local softening, but the latter is the more probable.

CASE OF HYDROPHOBIA.

Lately under the care of Dr. Taylor.

H. W., æt. 15, by occupation a "minder of hounds." Six or seven weeks ago he was bitten in the left arm by a strange dog in the street, which was said to be rabid, and was, accordingly, afterwards shot. He immediately rushed off to a surgeon (Mr. Garlick, of Tulse Hill), who (about 5 minutes after the bite) cauterised the two wounds, and under whose care he remained until the wounds were healed. Since the occurrence of the bite his mother has noticed that he has been drowsy and low-spirited, frequently sleeping during the day time, which he was not previously in the habit of doing.

Last Thursday, that is five days ago, he complained of pain in the upper part of the left arm and shoulder, of which but little notice was taken, it being put down as simply rheumatic, as he scarcely felt ill; indeed he was well enough to go to the school treat on the following day. But on Saturday this pain became much worse, and, at the same time, a peculiar violent spasmodic pain attacked him in the chest and stomach, which has been repeated in paroxysms, more or less, ever since. Last night he became delirious, having strange delusions and hallucinations, at times even violent, being with difficulty held down. During the intervals he was quite rational, recognising his mother and friends. The surgeon was sent for, who gave him chloroform by inhalation and a subcutaneous injection. He took no food or drink—the latter he closed his mouth against most obstinately, except at 10·30 this morning, when he took some baked custard and sponge cake, and sucked a little ice. At 9 o'clock this morning he vomited a quantity of brown coffee-colored fluid.

On admission, July 17th.—11·30 a.m. He was delirious and violent, requiring two men to hold him down. The muscular spasms were general, with the exception that he did not move his left or bitten arm so violently. He also has delusions connected with home occurrences, aud on one occasion was seen to attempt to bite a bystander.

Just above the left wrist are two nearly healed wounds, one in front, the other behind, but nothing special or characteristic is noticeable about them; he occasionally complains when this arm is held, that it is his "bad arm."

No spasms are observable in the throat, nor are any induced on offering him water, he resolutely closes his mouth against milk, declaring that he "will have none of it." After swallowing some, it brings on vomiting of a coffee-colored grumous fluid, some of which falling on my wrist gave rise to considerable smarting and in a couple of hours to a small vesicle, which, however, disappeared in the course of the evening.

The patient's face was much congested, the eyes rather prominent and staring pupils, variable; during the spasms dilating, and during the intervals contracted but equal. The features became contorted during the spasms, which were frequent and seemed to end only from mere exhaustion, and recurring on his having regained sufficient strength. No spasm was occasioned by a draught directly on his face.

12·30 p.m.—Temperature, 105·8°; pulse, 168, feeble and compressible. He was seen by Dr. Taylor, who advised no treatment as it was evidently too late. He was accordingly secured in bed and no remedy employed.

1·30 p.m.—Temperature, 105·5°; pulse, 150, only perceptible in carotids. Vomit the same as before.

2·15 p.m.—Temperature, 105·4°; pulse, 164. Spasms less frequent and violent. Clonic spasms of the extremities observable. Hands and feet cold and livid. Respiration, jerky. Keeps ejecting quantity of flatus from his stomach.

2·40 p.m.—Vomited again some similar fluid.

2·50 p.m.—Temperature, 105°. Becoming much weaker. No spasms; lying quietly on his back. Respiration, slow and gurgling. Mucus running from his mouth.

3 p.m.—Had one violent spasm and died. Temperature, 105°.

6 p.m.—Temperature, three hours after death, 95°. No urine was saved.

[We are indebted to the clinical-assistant in charge of the case, Mr. C. P. Creed, for the above report.]

Dr. SAYRE'S VISIT TO GUY'S.

Dr. Lewis Sayre, of New York celebrity, paid the hospital a visit last Friday, July 20th, in order to give a demonstration on his mode of treating Pott's disease and lateral curvature by an immoveable apparatus o Plaster of Paris. The operating theatre was well filled with students and a fair sprinkling of local practitioners, who had heard of his fame, and through the courtesy of our surgeons the operations were postponed to allow of full time for the demonstration.

Dr. Sayre, who was introduced by a few and appropriate words from Mr. Durham, commenced by making a few remarks on the causation of lateral curvature, showing, by means of a simple but ingenious model, the double curve and rotation of the vertebræ upon themselves in this disease, and maintained that such a state of things can only be relieved by taking off the spinal column the supercumbent weight of the head and shoulders, and pointing out how his method of treatment tended to procure this. The two chief objects of his treatment are, first, to procure extension of the spine, and, secondly, to fix the spine thus extended. This he does by suspension and fixation.

The subject to be treated was a young boy, of the age of 14, who had been under Mr. Durham's care in Lazarus ward since the 9th of August, 1876, with the exception of a few months at the end of last year, when he was sufficiently convalescent to be allowed to go home. The history of his disease dated from two months prior to his admission, and the symptoms have been increasing in severity ever since, being slightly and temporarily relieved by treatment.

When exhibited in the theatre he was seen to be greatly emaciated, the bony prominences of his ilia and ribs well evident through the skin. A hectic flush on both cheeks indicated the acuteness of the disease. There was a considerable knuckle of spine projecting opposite his second lumbar vertebra, with considerable redness over the sacrum and orista ilii. There were freely discharging abscesses on both thighs, running a considerable distance downwards, and much wasting of both limbs. The first process consisted in suspending the youngster (who could bear no weight whatever on his legs) from a high tripod by means of straps passing beneath his chin and both axillæ, so that he looked like a joint ready on the jack for roasting. All clothing had been previously removed from the boy, and a tightly fitting loosely woven "Jersey" stretched over his body and secured beneath the perineum, reaching from the clavicles to the pubes, the arms remaining free, care being taken to prevent any wrinkle or inequality in the garment. By this means Dr. Sayre maintained extension was induced, and the next proceeding consisted in fixing the spine in this extended position. This was done by Plaster of Paris bandages, previously prepared. These bandages, 3 to 4 inches wide, were of particular material and specially prepared, consisting of that kind of muslin known as "Crinoline," into the large interstices of which freshly ground dry Plaster of Paris is rubbed. These loosely rolled bandages were then placed in a basin of cold water, endways up, until all bubbles of air had ceased to escape, and afterwards gently squeezed to get rid of all the superfluous water.

They were then rapidly and very dextrously wound round the patient's body by Dr. Sayre's son, who assisted him throughout, commencing from the ilium and passing loosely but smoothly upwards to the level of the angles of the scapulæ, care having been previously taken to protect any projections of bone by felt plaster, and to provide for proper respiration and digestion by passing up a pad of cotton wool between the abdomen and the Jersey. Two or three thicknesses of this bandage were applied and the child taken down and gently laid on the couch; the pad of cotton wool was then removed, and the pressure of the contracting Plaster of Paris splint removed from off the spines of the ilium by manipulation. Dr. Sayre omitted in this boy one portion of his treatment, namely, the insertion of perforated slips of flexible tin between the layers of the bandage, giving, as his reason, his emaciation. The boy was then removed to bed, somewhat frightened but apparently relieved.

Dr. Sayre then announced his intention of giving a second demonstration on the following Wednesday, and finished his demonstration by giving a few practical hints on his treatment.

There is not much to say on the after history of the boy: he complained bitterly of pain now and then for a day or so afterwards, especially in the epigastrum, but this was probably gastric in its origin, as it was greatly relieved and soon disappeared after an attack of sickness. When seen a few hours ago he seemed very happy and comfortable, and greatly enjoyed being allowed to sit up out of bed for a couple of hours. The discharge from the abscesses is less in quantity, and there is already a marked improvement in the youngster's looks and general health.

NOTES FROM THE WARDS.

NOTES ON SOME CASES UNDER THE CARE OF Mr. DURHAM.

Martha 19.—*Strangulated Femoral Hernia, Carbuncle.*

S.T. æt. 64, married, 3 children. Admitted July 2nd. Has had a right femoral Hernia for 46 years. This was operated on by Mr. Birkett 7 years ago. She has worn a badly fitting truss for the last 3 months. For a week before admission, she had vomited severely, had pain at umbilicus and at the seat of the hernia.

On admission patient was vomiting a bile stained fluid; she complained of severe pain at umbilicus and in right loin, had an abdominal expression, dry tongue, rapid pulse, tympanitic, and a large femoral hernia ascending above Poupart's ligament to the level of the umbilicus.

Opium was exhibited and the hernia reduced.

The patient did well till 13th July, when she had some difficulty in opening her mouth. In front and below the right ear there was a dusky red, indurated, painful swelling, doubtful fluctuation. Temperature 102°, Respiration 103, Pulse 124.

Quinine Sulph. gr. iii 4 tis. his.
Brandy 6 ozs. Milk, Ice, &c.
Poultice and Gargle.

July 18th, Pointing out half-a-dozen places over swelling laid freely open; Slough exposed, Temperature normal. Progress favourable.

Martha 5.—Harriet Whitehead, æt. 57. Admitted *June 20th*, 1877. Enjoyed good health till the last two years. Five months ago the right knee swelled suddenly. Liniments Blisters, &c., were used with little or no good effect, and the leg has gradually been becoming flexed on her thigh, and the joint enlarging.

On admission, Patient looks older than she really is, and is much emaciated. There is a globular swelling of right knee, (size of cocoa-nut) fluctuating in parts but doughy in others. Condyles of femur apparently expanded, skin hot, tense and injected. The leg is drawn close up under her, and causes pain if moved.

June 23rd.—Pain in the knee prevents patient from sleeping. Patient is getting worse, so Mr. Durham advised her to have the thigh amputated.

June 26th.—Amputation was performed through the thigh by antero-posterior flaps, arteries atturo-matous, silver sutures. Since the operation the patient has been better. Temperature not above 100°. The wound has been dressed antiseptically. The sutures were removed on July 10th. Wound united in front, except at one point.

Martha 8.—*Syphilitic ulcer of Tongue.*

E.S. æt. 44. Married, 1 mis, 1 still birth, 9 children living. Admitted July 3rd. Shortly after marriage the early syphilitic symptoms appeared. Two years ago she noticed some slight fissures on her tongue. These have been extending slowly. She has also observed that the glands along the right sterno mastoid have enlarged.

On admission, the tongue is swollen and hard. There is a fissured ulcer occupying most of anterior part of the tongue. The glands are considerably enlarged.

Ung. hydrag.
Quin. Sulph. gr. j.
Port Wine 6 ozs.

The enlarged glands have nearly subsided, and the tongue is healing satisfactory. The chief interest about this case was its resemblance to a malignant form of sore.

Lazarus 19.—*Papilloma of Foot.*

W.F.S. æt. 62. Admitted June 27th, a healthy man—never had syphilis.

Nine months previously, from the irritation of a bit of sand a small sore was produced between the great and next toe, this did not heal, a warty growth started at that point and spread over the dorsum of his foot up to within half an inch of his ankle joint, it implicated the toes, and similar patches were scattered about the sole. It was extremely painful and prevented him getting about.

July 3rd, Symes amputation. There was some febrile disturbance after the operation, which has now subsided, and there is promise of an excellent stump.

Accident.—A case of fractured base, about which there was nothing special, except that recently he had internal squint of the right eye and long neck.

Samaritan 19.—A case of Chronic Orchitis, 6 years, with abscess and probably a hydrocele.

UNITED HOSPITALS ATHLETIC SPORTS.

The Eleventh annual meeting of the United Hospitals Athletic Club was held on Wednesday, June 4th, in the presence of a large and fashionable company. Guy's men and their friends showing up in great form. The Grand stand was quite, though not, as in previous years, unconveniently filled; thanks to the limit placed on the numberof the grand stand tickets and the body of the ground showed no lack in the number of visitors. Several members of the staffs of the various Hospitals were to be seen strolling about, and apparently greatly enjoying the closely contested and exciting races, Amongst them we noticed Mr. T. Smtih, Mr. Morrant Baker,

Mr. Clement Lucas, and Mr. Fred. Durham, though without doubt many more were present. The whole tone of the sports was most enthusiastic, and the various races well contested. Very exciting was the competition for the high jump; and Graveley who at first did not jump in his usual form, soon showed his competitors what he could do when he tried; and loud and hearty was the cheering when the two Guy's men cleared 5ft 3 inches, the St. George's man having kicked the bar at 5ft 2¼ inches.

Thanks to the ability of our champion J. G. Graveley, the Shield again falls to Guy's for the fourth time, St. George's and King's having each held it three times out of the ten years of its existence.

The proceedings were enlivened by the harmonious strains of the Royal Artillery band, and the prizes at the termination were presented by the hands of Miss Hewitt, the daughter of the president of the club for this year.

Appended is a detailed account of the various races.

Handicapper of Strangers' Race—E. T. Sachs. *Starter*—E. B. Turner. *Judges*—F. R. Cross and Dr. E. Hicks. *Referee*—A. B. Kelly.

100 *Yards Race.—First Heat*: H. T. Griffiths, St. George's, 1; A. Willis, St. Bartholomew's, 2; J. E. Lane, St. Mary's 0. Won easily. Time, 10⅕sec.—*Second Heat*: H. T. W. Blakeney, St. Bartholomew's, 1; G. Chitty, University, 2. Won by two yards. Time, 11¼sec.—*Third Heat*: R. P. Bond, King's, 1; R. M. E. Atthill, St. Thomas's, 2; J. W. Clark, Charing Cross, 3. Won easily by two yards. Time, 11⅕sec.—*Fourth Heat*: A. A. Bowlby, St. Bartholomew's, 1; W. J. Penny, King's, 2; C. Wallace, St. Thomas's, 3; J. Shepherd, Guy's, 0. A good race, won by a foot; a yard between second and third. Time, 11⅕sec.—*Final Heat*: Bond, 1; Blakeney, 2; Griffiths, 3; Bowlby, 4. Bond just managed to win by six inches after a grand race all the way, Griffiths a foot behind, and Bowlby a good fourth. Time, 10⅖sec. Under the rules the second in the winner's trial heat can challenge the second in the final, and Atthill availed himself of the privelege, but Blakeney beat him very easily.

Throwing the Hammer.—E. Jennings, St. George's, 82ft 7in, 1; F. White, St. Thomas's, 2.

120 *Yards Hurdle Race*, 10 *flights.—First Heat*: J. G. Graveley, w.o.—*Second Heat*: J. E. Lane, St. Mary's, 1; W. H. Addison, King's 2; J. D. Priest, St. Bartholomew's, 3. Won with ridiculous ease, the second man not being over the last hurdle when Lane breasted the tape. Time, 17⅕sec.—*Third Heat*: A. G. Routh, University, 1; C. Wallace, St. Thomas's, 2; J. Reader, Guy's, 3. Reader led to the seventh hurdle, at which he stumbled, and Routh and Wallace both passed him, the former winning by two yards. Time, 19⅖sec.—*Final Heat*: Graveley, 1; Lane, 2: Routh, 3. The three kept well together for six hurdles, and then Graveley and Lane drew away from Routh; the former, aided by Lane's tipping his last hurdle, winning by four yards. Time, 16⅗sec.

Putting the Shot.—J. A. Fraser, Guy's, 32ft 8in, 1; J. G. Graveley, Guy's, 30ft 8in, 2; E. Jennings, St. George's 30ft 4in, 3; J. D. Priest, St. Bartholomew's, 0: E. F. White, St. Thomas's, 0.

One Mile Challenge Cup.—W. S. Warlters, St. George's, 1; F. Parish, University, 2; H. Harvey, St. Bartholomew's, 0; Warlters led off at a slow pace, and kept in front till half-way down the straight, when Parish passed him, and kept a clear lead until they again reached the hospital end of the grounds. Here Warlters drew up to his shoulder, and for the remaining half of the journey they ran side by side, and at a much better pace. Fifty yards from the finish Parish hung out signals of distress, and Warlters, running very gamely, got in front; Parish, being run completely out in another twenty yards, pulled up, and Warlters won by about eight yards. Harvey gave up early in the race. Time 4min 41⅕sec.

Half Mile Race.—H. W. Yate, St. Mary's, 1; W. S. Warlters, St. George's, 2; J. M. Biggs, University, 3; W. H. Crosse, Guy's, 0. Crosse showed the way up to the straight and round to the railway side, where Warlters went to the front; but he had to give way to Yate at the hospital end, the latter maintaining his advantage to the finish, and winning by four yards; Warlters a yard and a half in front of Biggs. Time, 2min 9⅗sec.

High Jump.—J. G. Graveley, Guy's, 5ft 4¼inch, 1; V. V. Chapman, Guy's, 5ft 3¼in, 2; H. W. Shettle, St. George's, 5ft 2¼in, 3; J. W. Clark, Charing Cross, 0; J. Reader, Guy's, 0; E. F. White, St. Thomas's, 0; M. S. Wilson, King's, 0.

Quarter Mile Race.—M. S. Wilson, King's, 1; R. M. E. Atthill, St. Thomas's, 2; E. Barratt-Smith, St. George's, 3; F. Parish, University, 0; W. H. Crosse, Guy's, 0; E. Jennings, St. George's, 0; J. S. E. Colman, Charing Cross, 0; A. A. Bowlby, St. Bartholomew's, 0; R. J. Wilson, St. Mary's, 0. Smith was the first to show in front, and with a clear lead, he made the running to within a hundred yards of the tape, when he was passed by Atthill, who was shortly after challenged by Wilson. The latter, coming away in the last thirty yards, won by three yards; the same distance separating second and third. Time, 54⅘sec.

Wide Jump.—J. G. Graveley, Guy's, 20ft 5in, 1; F. L. C. Richardson, St. Bartholomew's, 20ft 1in, 2; E. T. Power, St. Bartholomew's, 19ft 3in, 3; R. M. E. Atthill, St. Thomas's, 0; A Willis, St. Bartholomew's, 0; Mr. S. Wilson, King's, 0.

250 *Yards Race*.—R. P. Bond, King's, 1; H. T. Griffiths, St. George's, 2; E. P. Clark, St. Bartholomew's, 0; G. A. Branson, University, 0; A. G. Routh, University, 0. Griffiths jumped off in front and led by three yards, which advantage he held till within fifty yards of the tape. when Bond began to catch him, and, after a fine race, Bond won by half a yard. Time, 26⅘sec.

Three Miles Race.—H. C. Howard, St. George's, 1; H. W. Campbell, Guy's, 2; W. B. Stebbing, St. Bartholomew's, 3; W. C. Falls, St. George's, 0. Campbell led for three parts of a lap, and then Howard, going to the front, had matters his own way, eventually lapping Campbell just before completing the distance. Campbell beat Stepping by a hundred and fifty yards for second place, and Falls gave up before going half the journey. Time, 17min 7sec.

One Mile Handicap, Strangers' Race.—F. B. Montague, L.A.C., 90yds, 1; E. W. Parker, L.A.C., 100yds, 2; W. Stevenson (introduced), 50yds, 3; C. C. Bowlby, late Harrow School, 70yds, 4; H. W. Hill, L.A.C., scratch, 0: S. K. Holman, L.A.C., 12yds, 0; A. P. Smith, L.A.C., 15yds, 0; W. Earle (introduced), 40yds, 0; E. Cazenove, late Forest School, 65yds, 0; J. C. James (introduced), 70yds, 0; S. J. Tailby (introduced), 75yds, 0; G. J. Mawby (introduced), 75yds, 0; H. S. Bevington (introduced), 80yds, 0; A. Swift, L.A.C., 85yds, 0; C. J. Tapp, L.A.C., 95yds, 0; C. W. H. Henderson, L.A.C., 95yds, 0; J. A. Voelcker, L.A.C., 95yds, 0; J. A. Squires, L.A.C., 135yds, 0; C. M. Callow, L.A.C., 140yds, 0. Bevington seemed anxious to get to the front, as he quickly passed Swift, Montague, Tapp, and Henderson, and as they passed the post the first time the first four were Squires, Callow, Voelcker, and Bevington. On the second lap Swift drew forward, and at the far corner took the lead from Squires, Bevington being third man as they completed the lap, with Montague, close up, fourth, The whole field at this point were well together; but one or two, Hill amongst the number, gave it up. Montague ran into third place as soon as he turned into the railway stretch, and passed both Squires and Swift before reaching the next corner. He came into the straight with a good lead, and easing up, won by 5 yards from Parker, who came out of the ruck in the last hundred yards along with Stevenson and Bowlby, beating the former by five yards for second place; Bowlby four yards behind. Time, 4min 26⅗sec.

Consolation Race, 300 *Yards*.—Penny, King's 1; Brauson, University, 2; Crosse, Guy's, 3. Penny led all the way, and won by three yards. Time, 37 sec.

GUY'S HOSPITAL GAZETTE, *JULY*, 1877.

OLD Guy's men coming up to our Annual Conversazione at the commencement of next Session, will notice many and various improvements in the hospital and medical school since their day. A new physiological laboratory and extra class rooms are being provided by extending the museum buildings forward to the pathway, level with the dissecting room—and, when finished, the new facade will add greatly to the architectural appearance of the school buildings. We hope, in a future number, when the buildings are further advanced towards completion, to give a fuller description of them. Another, and we must confess a vast improvement, will be noticed in the instrument department of the hospital. It is not, perhaps, perfect; but now, when required, the necessary instrument is to be found not only at hand, but in proper working order. Great credit is due to our present instrument man, Mr. COLE, for the great care he bestows in keeping the instruments in good order. But perhaps the greatest advance in this department has been made in the electrical branch. No one, entering the electrifying-room now, could fail to be struck by the great improvement made in it during the last few weeks by our newly appointed electrician, Mr. P. W. SEYMOUR; the room is now fairly well stocked with the necessary galvanic and electrical appliances, although many of them are the private property of the electrician; and we hope the day is not far distant when the hospital authorities may see their way plainly to provide a sufficient number of the necessary apparatuses for the proper carrying out of this very important branch of general therapeutics.

We would also call attention to a very great improvement, made certainly not before it was wanted, lately introduced in the nursing department of the hospital and briefly alluded to in our last issue, whereby the nurses in the several wards have been relieved of their scrubbing on alternate days, and a special staff of scrubbers instituted; so that now a dresser will not have to call a nurse from off her knees to come and assist him in dressing a case of excision of the knee, or the like.

We hope things will not end here, but that these improvements will lead to others and better ones. Why should Guy's Hospital, a hospital and medical school of which we are all proud, be behind other smaller and less known hospitals in the matter of minor details of its internal economy? and, as further improvements we would suggest amongst other things, an easily workable and accessible hydraulic lift to the top of the new building, and speaking tubes for communication with each ward from the colonade, and we hope before long to congratulate the hospital on their construction, for it is to be lamented that a large hospital like ours, has so long remained without such positive necessaries.

ONCE more does Guy's come to the fore carrying everything before it, as it should be, and hearty are our congratulations on its encouraging success. Our Hospital takes the lead in the College Examinations, far outstripping any of our rival hospitals. The percentage of men rejected amounts we believe to only 10 in the hundred, an average never before attained by us or any other school; our average of last year 15 per cent. was considered very good, and that is completely put in the shade by this year's success. We hope to give our readers in our next issue, a tabular account of the College of Surgeons Examination statistics, provided the College authorities follow their annual rule of publishing them.

In the field likewise we take the lead, both in athletics and football. Once more are the walls of our library graced with the handsome Challenge Shield, the lustre of which is only heightend by the neighbourhood of the Football Challenge Cup. The presence of these two trophies speaks highly for the manly and athletic vigour of the hospital, a superiority we are justly proud of and on which we heartily congratulate ourselves.

PHYSICAL SOCIETY.

At a meeting of the Presidents of this society lately held, it was determined to establish in addition to the two prizes of £10 and £5, for the two best papers read before the society, and a prize of £5 to the student who most distinguished himself in the debates, two further prizes of £5 each for the best essays on certain subjects, viz., £5 for the best essay on

"Chorea," and £5 for the best essay on "The localization of the functions of the brain."

The presidents are very anxious to receive the names of gentlemen wishing to read papers, and would be glad to be communicated with on the subject before the 1st of September.

HYSTERIA.

Second Prize Paper read by Mr. P. Horrocks before the Physical Society Oct., 21st, 1876.

(Continued from our last.)

Take tumours which are visible and palpable things, these people can cause peculiar contractions of the muscles so that a tumour is very closely imitated. Take anæsthesia which can be tested, these patients will endure any amount of pinching or pricking, which it would be quite impossible to bear in an ordinary state.

Perfect hemianæsthesia is most frequently due to Hysteria. Paralysis is often simulated; these cases can generally be diagnosed not only by the age, sex, and general appearance and conduct of the patient, but because of some actual difference in the two cases. Take an example of Hysterical hemiplegia; it is quite impossible for these patients to cause paralysis of one side of the mouth, so that it falls down and becomes expressionless as in true hemiplegia. Again, instead of the lower limb dragging behind them in walking, they hold it up and say it is paralysed, a thing impossible if it were. An amusing instance occurred in Addison Ward, some months ago. A strong young woman came in with paralysis of one leg and partial aphasia. When compelled to stand on her feet, she held the affected limb in advance of the other and quite away from the ground. Suddenly the physician said "why you are using the wrong leg," she was so confused that she hurriedly put down the bad leg, stood on it perfectly well and lifted the other up.

A strong galvanic battery made her both walk and talk, and very glad she was to go home. In some cases of hysterical hemiplegia the patient drags the limb along as she walks, and it does not perform circumduction, and unlike real hemiplegias who look at their feet as they attempt to walk, these patients stare at the bystanders.

Paraplegia may be simulated.

Duchenne says that in these cases the electro-muscular sensibility is diminished. Sir William Gull used to lay great stress on coldness, pallor of the limbs, and absence of wasting in hysterical paraplegia.

Another form which Hysteria may take is a contraction of certain muscles, whereby all sorts of fantastic shapes are assumed. The leg may stiffen in extension or be flexed rigidly at the knee. There is a girl now in Clinical with her head bent firmly on one side.

These cases frequently recover suddenly and no doubt the miraculous instances of sudden cures are of this kind.

During the fortnight following the death of the late Napoleon, Sir James Paget was consulted for stone in the bladder, by no less than four gentlemen who had nothing the matter with them. And this leads me to speak of a form of Hysteria which is frequent in males, and perhaps more so in our own profession than in any other class of people. How many students are there of one year's standing or more, in this hospital or any other, who have not imagined and really become convinced, that they were suffering from some disease, generally a fatal disease.

I myself must confess that I have since coming to Guy's been thoroughly convinced that my heart was diseased. After a time, however, I felt that I was labouring under a great delusion, it was not my heart after all, it must be my lungs. I remember listening with breathless attention to Dr. Habershon, as he lectured on Phthisis, for I was so convinced that my chest was affected, that I had not at that time called up sufficient courage to read it in books, for fear of finding out without any doubt, that I was a doomed man. One thing I however could not get over, and that was that phthisical patients lose their appetites. I have never had that symptom yet, and so after all I may only have been suffering from mental delusion. I am not alone in this kind of thing, scores of students consult yearly, medical men for complaints of which they have not a single symptom. Ask any of our staff, they have had ample experience and will fully bear out what I have stated.

Diseased joints are very often simulated, and you will not be surprised to find that those joints are oftenest affected hysterically which are oftenest diseased really, that is the hip and knee. Deformity of a joint is a sure sign of real disease and wasting of the muscles about it, is very confirmatory. If there is no swelling nor heat about a joint it is probably not diseased. If the joints and feet are hot at night and cool in the day, it is Hysteria we are dealing with. Slight pressure over these joints is exquisitely painful, whilst more deeply seated pressure is less so. There is a girl now in Charity Ward with hysterical knee joint.

There is one thing to be avoided in all cases of Hysteria, and on this I wish to lay great stress, I mean overlooking organic diseases when this is complicated by Hysteria. Supposing a girl is hysterical and at the same time phthisical, the least attempt on your part to examine the chest causes her very great pain; she cannot endure your stethoscope on her chest much less any percussion, so that you are unable to decide positively. In these cases never give a definite opinion as to whether she has a serious disease or not. For if your patient has phthisis and you think it is only Hysteria, and so tell the friends she will get all right, you may be bitterly disappointed and lose much credit. On the other hand, take a case of simulated insanity; and many hysterical patients there are who really appear like insane people, you might sign a certificate

and the patient might actually be sent to an asylum, when really she was only hysterical.

It must be obvious to you that it is of the first importance to ascertain the absence or presence of real disease, you will seldom fail in finding some amount of Hysteria. It has been said that all women are more or less hysterical, I doubt this, for I have known some women whom I should entirely acquit of having any o ne symptom.

With regard to the etiology of Hysteria, this is at the present time really not known. In Aristotles time it was supposed to be due to the womb moving about in different parts of the body, and so giving rise to the different symptoms. Even now though we know the uterus has no such locomotive powers, yet we must acknowledge that the generative organs play a most prominent part in Hysteria. In the majority of cases in women, there will be discoverable some disturbance of them. Menstruation will be irregular or the ovaries will be tender. Unsatisfied sexual desire is said to bring it on, but I don't think this is at all frequent, it is certainly not more frequent in widows, or in wives with impotent husbands than in other people. Masturbation and general excesses have been assigned as causes. Uterine irritation, ulceration and induration of the cervix, flexions of the womb, hyperæsthesia of the ovary, have all been brought forward by different observers as causes of Hysteria. Charcot says pressure over the ovaries will cause pain, and bring on an hysterical paroxysm, and in some cases it will stop an impending paroxysm.

Men who have hysterical fits are generally beyond middle age, and have been overworked mentally or are physically weak. Many there are who go into fits because it elicits so much sympathy and attention. But on the other hand, many have them because their nervous force is not got rid of in other ways, and so explodes in this manner. That is one of the theories of epilepsy, and I believe greatly in the accumulation of nervous force. How difficult a matter it is to keep children quiet and attentive for long at once! Probably this results from the fact that this same nervous force which is very active in them, has to be got rid of in some way, and so they have a constant desire to move or play, or in some other manner blow off a little super-abundant steam. I have heard of a teacher in a school, allowing all the scholars to shout at the top of their voices for a few minutes every half hour, in order that their nervous force might not accumulate to a dangerous pressure. So I think some forms of Hysteria due to pent up feelings.

Sydenham refers it to a disorder of the animal spirits which fall down into exquisitely and acutely sensitive organs, causing pain and spasm, and compares it to the concentration of the sun's rays by means of a glass. Other parts meanwhile being deprived of their proper supply of spirits become cold. This energy if directed into a proper channel causes such persons to do well in anything they may undertake. Hereditary disposition has a very great influence. If a girl has an hysterical mother she is almost certain to be hysterical herself. But quite as potent a cause is the manner in which a person is brought up.

It is very contagious. If a patient has an attack of Hysteria, several in the same ward will probably also be seized with an attack. It is a strange fact that the nature of the phenomena is often determined by the particular kind of sympathy which is bestowed:—If, for example, her loss of appetite is bewailed, she soon ceases to eat altogether; if her wakefulness is commented upon, she becomes almost sleepless; or if her paleness is made matter of anxiety, she becomes still paler.

But though we so often get uterine disturbance we may sum up by saying Hysteria is essentially a nervous complaint, and as such can be excited by the most various causes, uterine or otherwise.

Of the diagnosis I have necessarily had to speak, throughout my general description.

The prognosis is extremely favourable. very few die, though there are well authenticated fatal cases recorded.

Treatment.—These patients are often treated as though they were feigning their symptoms, which is a great mistake. Dr. Wilks says they deceive but can't help deceiving, and Holmes says the pain they feel is as real as the pain of any other disease. It is useless to tell them that nothing is the matter, you must make it appear that you perfectly understand the case, and know positively what will cure it, and in that way you may employ various methods of taking off her mind from the part, and at the same time shewing her that you are all the time attacking the disease which to her is a reality. I remember a patient in Dorcas Ward with hysterical knee joint. For several weeks nothing was done, and she was laughed at, but she did not get better. Then galvanism was tried and though she dreaded it every morning, she got no better; but when we put a splint on and bound it up she got rapidly well and went home cured.

The brother of this girl had had his leg amputated for diseased knee joint four years previously, and she had been suffering from hers for nearly four years. There was obviously a close relationship betwixt the two. Her mind was very susceptible. In fact these patients as a rule are very susceptible, and in our treatment we must bear this in mind and make use of it. Removal from home to the hospital away from sympathising friends is often of signal benefit.

Strong emotion such as sudden fright will sometimes effect a cure.

A patient in one of the medical wards at Guy's had been in bed with hysterical paraplegia having been unable to stand or move for a year or two, when one night a male patient got out of bed in delirium, seized a bar of Iron, and rushed in his night-shirt, into the

female ward. This woman was so terrified that she jemped out of bed and rushed down the ward, her paralysis being quite cured from that moment.

During a paroxysmal attack you may do a great deal if the friends will permit it. You may try cold water, or galvanism, both of which I have seen effect speedy relief. The most judicious method of using these remedies, is to use them once, and if this does not succeed, to say aloud that you are about to use them again, as soon as you have got your battery stronger, or your water in greater abundance.

I have seen ammonia applied to the nostrils with and without effect. Valerian, Assafœtidu, Galbanum, and many other drugs are given as medicines, and are often very useful.

But the treatment of hysterical patients speaking generally must be varied according to the circumstances of the case. If a student thinks he is diseased, it is best policy to tell him that he is entirely mistaken, if this is done by some one in whom he has great faith, it is the very best antidote. With women it is different, I have before advocated that they should not be told that nothing is the matter. But with them firmness on your part is of the first importance. If you don't govern her she will govern you. It may often be difficult to persuade the friends to adopt stringent measures, but it is very possible to be *suavitor in modo* and at the same time *fortiter in re*. Treat the various symptoms complained of as they arise, never appear to neglect anything she may say, just because you think it is all imagination on her part, and on the other hand, don't make too much of her complaints, or that will fasten her attention on them and so make matters worse. Change of air, exercise, travel, avoidance of all enervating habits are of essential importance. Galvanism, is of very great use in various forms of paralysis, opium, belladonna, blisters too, may be used for the relief of pain.

Often you will be taxed to the utmost, but you need never despair. One thing having failed, try another. Above everything never allow these patients to have their own way, or they will lead you as they lead their friends. Keep the reins in your own hands; govern your patient by a will, stronger than her own perverted will, and by judicious management you will in the great majority of cases, be enabled to rescue her from a very pitiable condition, and to restore her to a rational state of existence.

Correspondence.

To the Editor.

Sir,

In proposing a remedy for the "Scepticism" with which he charged Modern Medical Students, the writer of the article in your last month's issue suggested among other things that Clinical Teachers should devote themselves to discussing the skilful treatment rather than the accurate diagnosis of disease. Unless your paper is more worthily occupied, I would ask to be allowed to give some reasons why, with all due deference to the writer, I must beg to disagree with him. And first, it seems almost a truism to say that our success in life depends on the success with which we treat our patients.

Of course it does. But surely that success depends a little on our knowing what ails them. To cure, we must know what the disease is, and how to treat it when we recognise it, and it would be absurd to say that one item of knowledge was of more importance than the other. Both then, being of equal importance, the only point in discussion is the best way of acquiring the requisite knowledge, and of so storing it that it shall be available when wanted. The means are two fold, from books and from observation, and under the latter head I would place Clinical teaching, for it is the observation of the student directed by facts, by the experience and greater knowledge of the teacher, whilst on the other hand Systematic teaching is more nearly allied to book learning, the memory being exercised in retaining a series of assertions, which he will afterwards verify by experience. These then being the ways of getting our two departments of knowledge, diagnosis and treatment, I shall try to show that the last is best learnt from books, as the first is from observation, or rather perhaps I should say, that not having time to learn all from observation, treatment is that part which can most advantageously learnt from books, and for these reasons it is a thing we have to acquire from the experience of others; we have no reasoning to guide us, all (or almost all) our remedies must be used empirically, used in one case because they have been used in a similar one with good results; now all this must be *learnt*, it is not possible that by any process of deductive reasoning we could evolve the correct drug to employ in a given case; the mental effort is chiefly one of memory and not of reason. As therefore it is necessary to get knowledge of treatment by the experience of others, it seems to me to matter little whether we acquire it by reading the records of experience in books, or by listening to the words of a lecturer. But with diagnosis the case is different, no amount of book learning will help us, unless it be largely supplemented by practical experience, and how is this to be gained but by accurate observation under skilled teachers? Let a man read for an hour about an amœba, will he thereby know it under a microscope? possibly, but does any one pretend that he would have as innate a certainty about it as one who has had its peculiarities pointed out to him by an old acquaintance of the creature? Similarly how long might a man read about measles, before he could recognise even the rash, and even if he did, what a poor sort of knowledge it would be compared to that of one who had had all the little details of the case pointed out to him by an able teacher. For the latter would have had given to him, each link in the chain of reasoning, as it influenced the diagnosis of the physician, and so he would acquire the habit of noticing the symptoms of a case before he knew what the diagnosis was, then of arranging them, not as in a book, but in the natural order in which they occurred in this particular case, and finally in deducting the facts so seen, a correct conclusion. Now surely in this process of reasoning it is fit that we should have the assistance and guidance of those whose whole lives have been spent in similar pursuits, and surely their knowldege is more useful to us, when so employed that when discussing the merits of remedies so uncertain in their action that two men equally eminent shall totally disagree as to their value, and moreover the partialities of every lecturer for certain modes of treatment, seem to me to show that they ought rather to teach diagnosis, for it is confusing to find the same remedies alternately debased and exalted, according to the teacher who speaks of them. But the habit of carefully noticing all the symptoms of a case, of arranging those symptoms, of appreciating exactly the diagnostic value of each, of weighing the probabilities of the conclusions to which they lead, and thus from an apparently disconnected mess of facts, drawing a

rational diagnosis; this requires a carefully educated habit of mind, and to this end, I humbly submit that even the hours spent in following the train of reasoning necessary for focussing a "cerebral tumour to the exact square centimetre which it occupies," is very, very far from being wasted.

Not without much diffidence, I have attempted to show that plain common sense, appears to support our Clinical teachers in their mode of instruction, and, I am Sir,

Yours obediently,
A SECOND YEAR'S MAN.

[The above letter was crowded out from last month's Gazette.—Ed. G.H.G.]

A PATIENT'S JOURNAL.

The following journal was found among the effects of a patient (male), lately in Luke ward under the care of Mr. Cooper-Forster; and we present it to our readers, as it was originally written, with but one or two minor alterations and omissions, to give them an insight into the private life of patients in the wards.

June 18th.—Letter to Mr. Cooper-Forster from Jones; hesitation as to going, confirmed by Morning Psalms. Half-past one. Porter's civility: give letter to Mr. Cooper-Forster, who orders immediately a bed to be got ready in the Luke ward, Guy's Hospital. Go to office for card; explain to clerk not prepared to stay, having made no arrangements. See sister, her advice is to get card at once, and bed is secured. Talk with nurse, find out all that is required to bring with me; start back; friends cheer me up; mind relieved upon having taken the plunge. First impressions: boy carried in, operation going on; patients being dressed by nurses, students' demeanour waiting the arrival of heads of different sections, also accompanying them round wards.

June 19th.—12 o'clock—Arrived at bedside. Nurse explained as to bath; told her I had taken one before I started; rule that everyone should have a bath before going into bed; did not know whether sister would take my word; seeing sister soon after, and explaining that I wished to take to my bed at once, was directed to do so. Delicacy as to undressing, nurse remarking I should be soon broken-in. Bed, iron, old fashioned and comfortable; no mattress, blanket next bed, linen sheets twice a week, two blankets, one scarlet blanket, one check, blue and white, cover taken off at night and the large scarlet blanket unfolded from sides about 4 o'clock. Twenty-one patients in ward, two nurses and extra assistance if required; charming and comfortable effects of flowers; the sister's fondness and taste for them, effective arrangements on stand near the door, on the tables, window-ledges, and iron stand at the bottom of the ward. Cupboards for patients' clothes. Two tables, trays with chemicals in, glass stoppered bottles engraved with name of contents; two basins and jugs, with soapdishes, nailbrushes and towels at each table for the use of the dressers and surgeons; tables, deal, well scoured top, painted legs, with large drawer for books for the reporters, about 5 feet by 2 feet 6 inches. Pictures, engravings, chromographs, and appropriate texts of scripture grace the walls. Lockers are placed by each bedside to hold your bread, butter, pint cup, knife and fork, or anything you may obtain for yourself as a relief to the plain bread and butter; eggs and marmalade are the favourite extras. Your tea is poured out of the immense brown jugs in which it is brought into the ward, boiling hot, and I shall not be doing the tea an injustice if I say it is capable of being made more palatable. The eggs for breakfast at six o'clock and tea at 5 o'clock are collected and boiled by one of the patients who may be well enough to get up, going round the ward with a small basket and marking each egg with the number of its owner; this is done with the greatest care, as almost all the eggs have been obtained by the thoughtful kindness of the friends or relations who have visited them. There is a woman who comes round the ward twice a week with eggs, but these are deemed inferior to those brought by friends, and hallowed by kindness. There is also another old lady who comes in daily, about 4 o'clock, with a basket containing shrimps and watercresses; I do not notice a large business done, as her visit is very short. There is also Trotty, the newspaper man, who comes round morning and night. I do not know whether a good judge of the equine animal would say much for the Trotter's pace or action, but, at all events, he is sure to come sometime, punctuality not being one of his failings; his urbanity cannot be disturbed, and his confidence and knowledge of the value of each periodical—Daily and Weekly newspapers, Family Heralds, London Journals, and cheap illustrated papers—cannot fail to make a deep impression, and add very materially to his takings.

Meal times are as follows:—

Breakfast at 6 o'clock;
Lunch at half-past 10;
Dinner at 1;
Tea at 5; and
Supper at 7.

Breakfast the night nurse attends to, each patient able to do so saves all the trouble he can, arranging his locker, cutting his bread and butter, and arranging his tablecloth, the latter being a newspaper, beating up his egg ready for the tea when it comes round; he may have, if he wishes it, his bread toasted, this being a privilege I think. After all have finished, a white basin (all the earthenware articles are white with the coat of arms and insignia of the Hospital done on them in black) is placed on the locker, and the nurse comes round with two large jugs, one with hot and the other with cold water, which she gives you as you wish; from your bag, made of check of the same pattern as the covers of the beds, which hangs at the

head of your bed, and which contains your soap, towel, hair-brush and comb, you take those useful articles and proceed to wash and arrange your hair, it is not deemed essential, to ensure a perfect success, that you should have a looking-glass, in fact I do not remember seeing one in the whole ward, and I am quite sure no fault is to be found with the appearance of any patient. It is wonderful how soon each patient derives a benefit from the influence of good order, neatness and cleanliness, and evidently acquires a spirit of emulation to make the most of himself, and yet without ostentation or folly.

The cup you have taken your tea from, the pot which held your butter, and any bread you may have left, are then collected, the two former to be washed and placed upon the table in the middle of the ward, and the bread taken downstairs in a basket.

The day nurses begin their duties at seven, and the first thing they do is to make the beds; tea leaves are thrown under the beds, and lockers swept out and dusted. No one, seeing how methodically, quickly, quietly, and thoroughly this is done, can fail to derive the benefit and advantage of feeling how much it increases comfort, health and happiness to fulfil any simple duty with judgment and method. The most afflicted patients are left until the last, they requiring two persons to get them out of bed; it being also advisable to get their beds made as quickly as possible and to disturb them as little as they can. The boys are then washed, well scoured all over with flannel and soap—there were three close to me, Bobby, Tommy, and Walter, the affection and obedience they always evinced towards their nurse pleased me beyond measure. The day I came in one poor little fellow, aged 9 years, had to undergo an operation for diseased jaw-bone, arising from neglected decayed teeth; I did not hear a murmur until long after the operation, and then an exclamation of "Oh! my poor face." To see the heartfelt sympathy of the sister and nurses, as they never passed the bed without some kind word or act to soothe him in his pain.

The floor is swept and cleaned from end to end, everything dusted, and such things and places as require scouring, thoroughly done. The sister then portions out the allowance of butter, and the milk or beer permitted to each patient, and places in each locker the small loaf of bread which is to last until the following morning, and should there be anything improper or out of order, a few words from her soon rectifies it. The sister gives all medicines with her own hand, carefully cleansing the glass after each administration.

Then come the dressers and reporters to attend to the patients who require their services, and then the house-surgeon comes round the ward, enquiring carefully after the health and condition of each patient, giving each a word of encouragement, and, as he leaves you, you feel a kind and sympathising friend has left you. The matron walks through the ward; I know not what her duties be, for our ward was too well regulated to require any supervision or remark, unless it were an expression of admiration of the plants and flowers, or the courtesy one lady would show to another.

The patients pass the time, if their state permit, in games, as draughts, go-bang, &c., reading and conversation amongst themselves, the latter often being very entertaining.

Between half-past 12 and 1 o'clock, dinner is placed on the table at the angle of the ward; a large white cloth is placed on the floor extending somewhat all round the table; the potatoes are brought up in their jackets and peeled by the nurse and any patients able and willing to assist.

The visiting surgeon goes round the ward on Mondays and Thursdays at half-past 1, performing any operation that may be required immediately, though the regular operating days are Tuesdays and Fridays.

Tea at 5 o'clock, much the same as breakfast; and at 8 o'clock all who have been allowed up are required to undress and get to bed, and at 9 all conversation must stop and silence reigns, broken only by the groans of those in pain; later on the dresser comes round and sees to the patients, and the last thing at night round comes the house-surgeon with so silent a step and so noiseless a footfall that patients often express their surprise to learn that he has passed. The nurses move with the same considerate quietude, their noiseless slippers making only a muffled sound.

VISIT OF THE CHINESE AMBASSADOR.

The Chinese Ambassador, accompanied by his secretary and interpreter, visited the hospital on Friday, June 16th, and was shown over the hospital by the Treasurer, Dr. Pavy and Dr. Steele. He was much amused by the benzoline cautery, and was not satisfied that it was hot until he had burnt his fingers. He also took great interest in the electrifying room, which has recently been furnished with a great many new instruments. Here he took "a shock," and then proceeded to inspect the museum and new building. In taking leave, he expressed himself highly gratified with the visit.

CHANGES ON THE STAFF.

The following changes have recently taken place in the staff of the Hospital Medical School. Dr. Habershon has resigned the lectureship on Medicine, and Dr. Pavy will occupy the vacant Chair. Dr. Pye-Smith will deliver all the lectures on Physiology, which he has of late shared with Dr. Pavy. Mr. Clement Lucas and Mr. Golding-Bird leave the dissecting room; the former having been appointed Demonstrator of Practical Surgery, and the latter Demonstrator of Practical Physiology. Mr. Jacobson is thus left head of the dissecting room whilst Mr. Carrington and Mr. Symonds have been ap-

pointed Demonstrators of Anatomy, in the place of Mr. Lucas and Mr. Golding-Bird, and Mr. A. H. Jones has been appointed Assistant Demonstrator.

Mr. Fred. Durham has been re-appointed Surgical Registrar, and Dr. Mahomed Medical Registrar in the room of Dr. Fred. Taylor and Dr. Goodhart, resigned.

DISSECTING ROOM NOTICE.

We would remind second year's men, and any men just about to enter at this Hospital, that their names for "parts" for dissection will be received on or after the 1st of September, and that the earlier they put their names down the sooner will they be able to get to work at their dissecting.

THE NEW COLLEGE.

We understand that the Governors of the hospital have been for some time discussing a plan for the erection of a college in which students may reside during session. The site selected is where the old Maze Pond Chapel used to stand, which, with the adjoining land, was purchased a short time ago by the hospital authorities. The building will occupy the angle between Maze Pond and New Street, and will face the interval between the new and old buildings. The plan, designed by Mr. Billing, architect to the hospital, represents a somewhat triangular building, in red brick, with Tudor windows and entrance brought out in white stone. The difficulty of obtaining comfortable lodgings in the immediate vicinity of the hospital has long been felt by students, and they will look forward with pleasure to the time when this building may be completed. The student who lives in college will have many great advantages, for he will be sure to hear of any rare case when admitted, and will be within call when any operation is about to be performed. We hope nothing may prevent this plan being speedily carried into execution.

ENTRANCE SCHOLARSHIPS.

Two open Scholarships each of 100 guineas, have recently been established at this Hospital, and will be competed for in September next.

The open Scholarship in science of the value of 100 guineas, tenable for one year, will be competed for on Tuesday, September 25th, and following days. The subjects of the examination are :—

Inorganic Chemistry.
Zoology.
Physics.
Botany.

The open Scholarship in the subjects of preliminary education of the same value, will be competed for on the same days as those fixed for the examination in science.

The subjects are :—

Latin—*Horace*, Odes Book 1; *Cicero*, Catiline Orations.

Greek—*Homer*, Iliad, Book 1. *Herodotus*, Book 1.

The candidate has the option of being examined in German instead of Greek.

German—*Fouqué*, Die Vier Jahreszeiten; *Goethe*, Egmont.

French—*Corneille*, Le Cid.

Euclid.—The first four books.

Algebra.—To quadratic Equations.

Arithmetic.—

No candidate will be allowed to compete for both Scholarships.

The successful candidate in each case will be required to enter at the Hospital as a perpetual pupil, in the October immediately succeeding the examination.

Names of intending candidates should be forwarded on or before Saturday, September 22nd, to

The Dean.

NOTES OF THE MONTH.

A Shameless Hoaxer.—Some of our contemporaries have announced the receipt by some of the metropolitan hospitals of very handsome donations from a Major Moriarty; and it is true that a cheque for £500 on the Provincial Bank of Ireland (Parsonstown Branch), and signed Denis Moriarty was sent, with a letter from "Major Moriarty," to the Great Northern Hospital; and one for £1000, similarly signed, to the University College Hospital. Two or three other medical charities also participated to a smaller degree in "Major Moriarty's" benevolence, so far as the receipt of cheques goes. But we regret to add that the cheques sent to the Great Northern and the University College Hospitals were returned, from Ireland endorsed, "No account at Parsonstown Branch"; and the letters of acknowledgment from the secretaries of the hospitals to Major Moriarty came again to them through the Dead-Letter Office. We fear the other charities honoured by the Major's approbation have also found his cheques equally worthless.

The following Guy's men have lately passed their primary examination in Anatomy and Physiology at the Royal College of Surgeons :—Messrs. H. Charles, S. T. Thomas, E. L. Brockliss, F. S. Pilkington, A. D. Deane, S. H. Moore, A. B. Shelswell, C. Sage, E. O. Stuart, J. W. Hodgson, F. Hitch.

The following gentlemen passed the examination for the L.R.C.P., Lond., on July 12th.—Messrs. J. Brett, M.R.C.S., A. C. Brock, M.R.C.S., W. M. Evans, M.R.C.S., C. W. Lacey, M. R.C.S., J. Mackern, M.R.C.S.

We are pleased to see that Dr. Habershon has recovered, and that he is once more able to attend to his duties at the Hospital.

The following Guy's men passed their "First College,' during this month.—Messrs. E. L. Brockliss; H. Charles; A D. Deane; F. Hitch; J. W. Hodgson; S. H. Moore; F. S. Pilkington; C. Sage; O. B. Shelswell; E. O. Stuart; and S. T. Thomas.

Mr. John Birkett, consulting Surgeon to this Hospital, has been elected President of the Royal College of Surgeons.

Dr. Stevenson has been elected President of the Society of the Medical Officers of Health.

Balsam of Peru as a Dressing for Wounds.

We regret that we cannot make good our promise of last month, to lay before our readers the result of a further trial of the Balsam. The number of Cases suitable for its application being scarcely large enough to allow us to come to a definite conclusiou as to its superiority over Friar's Balsam. In some cases it certainly was most successful; but these were cases in which most probably any similar application would have been equally efficacious; in others it most lamentally failed, especially in a very straight-forward case in the wards, of compound fracture of the tibia and fibula.

We understand that Mr. A. H. Jones has resigned the post of Assistant Demonstrator, to which he was lately appointed; so the appointment still remains vacant.

The Treasurer's Gold Medals.—The Gold Medal for *Medicine* has been awarded to Mr. P. Horrocks. The Gold Medal for *Surgery* has been awarded to Mr. G. A. Wright, B.A.

The Gurney Hoare Prize.—Gentlemen are reminded that the Essays and cases for this prize must be sent in before the first of October, to the Dean.

Voluntary Examinations.

Third year's Prizes.
1st.—Russell, £35.
2nd.—Hartley, £20.
3rd.—Walley, Honorary Certificate.

Second year's Prizes
1st.—Rake, £25.
2nd.—Crook, £10.
3rd.—Flanagan, Honorary Certificate.

First year's Prizes
1st.—W. E. Starling, £50.
2nd.—Fielden, £25.
3rd.—Sanders, £10 10s.
4th.—Scott, Honorary Certificate.
5th.—E. A. Starling, Honorary Certificate.
6th.—Phillips, Honorary Certificate.
7th.—Marsh, Honorary Certificate.

ON DUTY FOR AUGUST.

House-Physician:—Mr. T. L. Porter,
Junior House-Physician:—Mr. Ch. F. Pickering,
House-Surgeon:—Mr. W. P. Reynolds,
Junior House-Surgeon:—Mr. T. B. Brett,
Senior in Charity:—Mr. T. R. Judson.
Junior in Charity:—Mr. A. G. Barrs,

RESIDENT DRESSERS.

Messrs. Chubb.
" Davy.
" Wainewright
" Meek.
" Hammersley.

STATISTICAL REPORT OF LYING-IN CHARITY FOR JUNE, 1877.

Number of women attended			215
Recovered	215		
Died	0		
	215		
Single Births		214	
Dual		1	
		215	
Women attended in 1st confinement		35	
" " 2nd "		35	
" " 3rd "		28	
" " 4th "		29	
" " 5th "		17	
" " 6th "		12	
" " 7th "		15	
" " 8th "		14	
" " 9th "		9	
" " 10th "		12	
" " 11th "		5	
" " 13th "		2	
" " 14th "		1	
" " 18th "		1	
		215	
Children at full time.			
Males alive	114		
Males dead	4		212
Females alive	92		
Females dead	2		
Premature children, 6 and 7 months			
Males alive	2		
" dead	0		
Females alive	0		3
" dead	1		
Abortion		1	
Total number of children		215	
Alive	208		215
Dead	7		
Presentations.			
Vertex		210	
Arm		1	
Breech		2	
Face		1	
Foot		1	
		215	
Operations.			
Forceps	2		
Extract of Hydatidi from mole	1		
	3		
Externs attended.			
Mr. Ernest		50	
Mr. H. L. Manby		24	
Mr. S. R. H. Mathews		50	
Mr. Chas. Wood		40	
Mr. H. E. Walker		51	
		215	

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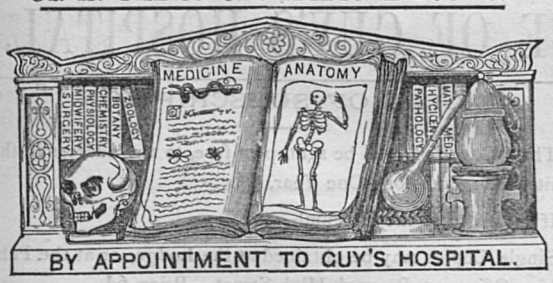

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Clinical Lecture.

By DR. PYE-SMITH, JULY 11TH.

A case of bronchitis described in a previous lecture having since died, Dr. PYE-SMITH made some remarks upon the terminations of bronchitis. Capillary bronchitis is a very fatal form, but, happily, not common, and mostly occurring in old persons. It invades the finest air tubes as far as the entrance of the lobules. The term "capillary" should not be taken as implying that these tubes are at all as small as capillary blood-vessels, but simply as denoting the tubes of the smallest calibre. Lobular pneumonia is a very common result of bronchitis in children. In this form the bronchitic affection passes beyond the openings of the lobules, and invades the alveoli themselves. This may terminate (1) in resolution and complete recovery; (2) in collapse or atalectasis, the affected portions of the lung becoming carnefied and airless. Many persons in whom this has occurred in childhood may live to an advanced age and enjoy fair health, though, perhaps, not equal to much active exertion. You may often observe in such, a constriction round the chest much resembling the mark produced by the pressure of stays, and indicating the boundary of the useless lung. A third termination is caseation. The cells of the catarrhal exudation become fatty, salts, especially phosphates, are poured out, and the fluid subsequently being absorbed a caseous mass is left. In the rare cases of lobular pneumonia met with in adults this termination usually occurs. Chronic bronchitis in adults usually terminates in either dilatation of tubes (bronchiectasis), or dilatation of vessels (emphysema). Often associated with these, fibroid induration or chronic interstitial pneumonia is met with. In the patient under notice bronchiectaris has occurred. On cutting into the lung, the large tubes are seen widely gaping. The dilatation is not usually of a regular uniform character, but more or less saccular. In all these forms dilatation of the right side of the heart is found, easily accounted for by the obstruction existing in the lung. Nevertheless, this condition does not occur in phthisis, probably because the slow formation of blood from the general mal-nutrition balances the pulmonary obstruction to its paasage.

TWO CASES OF ANEURISM.

A common disease occurring in several forms as a consequence of atheromatous change in the coats of the arteries. It can usually be traced to some excessive muscular effort, and is generally found in elderly persons, and more particularly in those whose occupations are of a laborious character, *e.g.*, soldiers, sailors, bargemen. Moreover, aneurisms are most frequently situated at parts of the artery most exposed to strain. It must be borne in mind that an artery may be exposed to two kinds of strain, one a stretching by active muscular efforts, and the other arising directly from the force of the circulation.

Clinical 15.—Man, age 50. Was 20 years a soldier. A large pulsating swelling in sternal region. This is probably involving the origin of the innominate artery, a very common situation. It is probably also fusiform, as there is no aneurismal bruit, a sign rarely absent in saccular aneurisms, but frequently so in large dilatations. It has not involved the ostium of the aorta, or we should have had evidence of aortic regurgation from the dragging apart of the valves, or of obstruction from extension of the atheromatous process to the valves themselves. There is no dysphagia or dyspnœa or other symptoms to indicate any affection of the transverse aorta. During the last few months the tumour has rapidly increased from the size of a billiard-ball to that of a fist. In one spot the integument is becoming soft and red. The aneurism will probably open here. Death will probably not be immediate; clotting will occur on the approach of syncope, but hæmorrhage will occur again and again and soon terminate life. If an aneurism opens into a serous tract, death is instantaneous. The treatment of these cases holds out very little hope. In early stage Valsalva's starvation method, aided by large doses of iodide of potassium, may induce coagulation of the contents of the sac. This case has gone much too far. As a desperate resort it is proposed to endeavour to cause clotting by the passage of an electric current by means of needles introduced into the sac.

Another case, 12 Clinical, is interesting from the obscurity of the diagnosis. The man is 33 years of age, and no guidance is afforded by his previous history. He was in the hospital last winter with a pulsating tumour in the breast, which gave him a good deal of pain. Getting somewhat better he went out, but has recently been again admitted into Clinical. There is a pulsatile swelling possessing many characteristics of an aneurism, but in a very unusual situation, occupying the right mammary region. There is no artery in this position except the external mammary, and it is difficult to imagine that so small a vessel could give rise to an aneurism of this magnitude. Is the tumour an aneurism at all? What other pulsatile swellings must be thought of? A very vascular new growth might occur and give pulsation. The only likely malignant tumours, however, would be osteoid cancer or lympho-sarcoma. But this has been existing for twelve months and has not increased in size, there are no enlarged glands, no cachexia, no pleurisy, all facts that militate strongly against the idea of a vascular growth. The fact of the apex being in the normal position disposes of the suggestion of its being a displaced heart. It might probably be a light cyst

(uch as a circumscribed pleurisy or hydatid) communicating pulsation from the aorta. The diagnosis is at present merely conjectural. Objections apparently valid may be urged against every possible suggestion.

[We are indebted for the above to Mr. W. DARLEY HARTLEY.]

NECROSIS OF SKULL. TREPHINING. DEATH.

H. S., æt. 40, admitted into Luke Ward, April 23rd, 1877, under Mr. COOPER FORSTER. Works as an engine fitter in Chatham Dockyard. Father, who had epileptic fits, is said to have died of some brain disease.

Patient's previous history has no particular interest, except inasmuch as the occurrence of two abscesses in perineo and of some eruption on the left leg tell a tale as to the possibility of venereal infection.

The patient entered the hospital chiefly on account of an abscess about the elbow-joint. The inflammation spread to the joint, which was excised; but, the excision being unsuccessful, the arm was afterwards amputated. As this part of the case had apparently no influence on the brain mischief, it will be left out altogether in the following report.

About a year ago was troubled with violent pains on the left side of the head, which never left him day or night. An abscess formed on the head, which reached the size of a hen's egg before the pus was let out by an incision. It has discharged ever since.

On admission.—Patient is an average size man, of a somewhat wasted and unhealthy appearance. On the head, about an inch to the left of the middle line, and about the junction of the anterior and middle third of the left parietal bone, is a discharging wound of small dimensions. The pus is offensive, and cakes on the hair around. A probe passes readily into the wound for a considerable depth and touches dead bone. Hair cut short and wound washed out with carbolic lotion.

May 1st.—Two small pieces of necrosed bone removed from scalp. The larger one about the size of a pea, rounded and porous.

May 3rd.—Less discharge from head since removal of bone.

May 29th.—At 3·30 p.m. patient had an epileptic fit lasting about fifteen minutes. He has never before had a fit of any sort.

From this date until July 22nd, when he had a second epileptic fit lasting twenty minutes, no head symptoms of any consequence were noticed. The wound keeps on discharging offensive pus, but no bone can be felt.

August 13th.—Another fit last night, which lasted twenty minutes. Since the last fit has been frequently subject to attacks of epileptic vertigo.

August 13th to 18th.—Continuance of attacks of epileptic vertigo with frequent spasmodic twitchings.

August 15th.—Burrowing discovered between dura mater and bone, extending from the wound for about two-thirds of an inch towards middle line.

August 18th.—Sickness commenced yesterday afternoon and has continued ever since; everything taken is brought up again. Appears in a very low condition and is perspiring profusely. Temperature, 100°. Pulse, 62.

Mr. JACOBSON trephined at 10 p.m., the operation being performed antiseptically. A crucical incision having been made at the seat of disease, the scalp was reflected off the bone. This disclosed a small cleanly punctured out hole in the bone, filled up with granulations springing from the dura mater. There was free bleeding. Medium sized trephine applied to the right of the opening, and crown removed by elevator. The dura mater exposed was rough and apparently sloughy. An incision was made in the dura mater, and a probe passed in; a very small quantity of yellowish material, proved microscopically to be pus, came through the opening. Nothing more was done, and the wound was left freely open. 5 p.m.—Temperature, 100°. Pulse, 72. Very drowsy; no sickness or twitching since operation. 10 p.m.—Temperature, 97·4°. Pulse, 84. Has been once very sick, since which a little brighter. Still drowsy. Slight general twitching noticed once.

August 19th.—11 a.m.—Temperature, 98·2°. Pulse, 76. Drowsiness continues. Very sick at 1·30 a.m. No twitchings noticed during night. No paralysis. Complains of much pain in head at seat of disease. 10 p.m.—Temperature, 97·4°. Pulse, 62. Once sick since the morning. Pain in head continues.

August 20th.—10·30 a.m.—Temperature, 98·3°. Pulse, 56. Less drowsy. Less pain in head. Free perspiration. No sickness, twitchings, or paralysis. Bowels not open since operation. Pulv. Calomel gr. v. statim. When spoken to seems clearly to understand, but answers reluctantly or with difficulty. 10 p.m.—Temperature, 97·4°. Pulse, 66. Calomel not acted. Brighter.

August 21st.—10 a.m.—Temperature, 98·4°. Pulse, 60. Bowels open, but not freely. Restless night, with a good deal of pain, the seat of which could not be ascertained from him. Much in same condition as yesterday. No paralysis. 10 p.m.—Temperature, 97·4°. Pulse, 60. Restless. Does not answer questions, except by shake or nod of head. Since morning has passed all his urine in the bed.

August 22nd.—10 a.m.—Temperature, 98°. Pulse, 60. Respiration, 14. Right arm and leg rigid and powerless. Sensibility cannot be tested as he does not answer when questioned. Semi-comatose; lies prostrate in bed, with eyes closed, taking no notice of anything; now and then heaves a deep sigh. 10 p.m.—Owing to the patient being either unable or unwilling to swallow, fed by means of tube passed down œsophagus. After this, for rest of day, swallowed

himself, but reluctantly. 8 p.m.—Temperature, 98·4°. Pulse, 104. Respiration, 28. Perspiring very freely. Pulse intermits. Continuance of right hemiplegia and rigidity. Left pupil dilated. Has passed motions under him.

August 23rd.—10 a.m.—Temperature, 98·4°. Continuance of hemiplegia, but scarcely any rigidity. Semi-comatose. Fed by tube with eggs and milk. 5 p.m.—Eyes turned to the left, and do not pass to the right beyond the middle line. Fed again; also at 9 p.m. 10 p.m.—Temperature, 99·6°. Continued in this comatose condition until 5·45 a.m., when he died.

Post-mortem.

At the edge of the trephine hole, towards the middle line, a small portion of the inner table ulcerating. A limited area of the dura mater much thickened and in a sloughy condition; adherent to the brain beneath. The membranes around this part infiltrated and adherent, but no general meningitis. The convolutions of both hemispheres flattened, but especially on left side. In the substance of the left hemisphere, a large circular abscess, about an inch in diameter, containing about half an ounce of offensive, thick, dirty-green pus. It commenced at a point on the surface (left ascending parietal and adjoining frontal convolution) corresponding to the diseased membranes; and its wall, which was fairly definite, was continuous with these membranes. The extra-ventricular portion of the corpus striatum was destroyed, and the intra-ventricular portion encroached upon. The rest of the brain appeared healthy.

Some pneumonia at right base.

Cortex of both kidneys somewhat wasted.

No evidence of syphilis in any internal organs.

The peritoneum was scattered over with small caseous masses; and a similar caseous mass, of much larger dimensions, and contained in a definite capsule, was situated between the liver and diaphragm, which were somewhat adherent.

VARICOCELE.

Communicated by Mr. R. A. BIRDWOOD.

The operative treatment of varicocele is attended with so great risk that most surgeons would hesitate before undertaking the radical cure of this affection.

The method most recently recommended in the G. H. Reports could not be practised without careful attention to the antiseptic details. We would, therefore, considering the difficulties and dangers of the recognized operations, refer our readers to some back numbers of the Reports, where an operation neither dangerous nor difficult, which we do not remember to have seen practised—is sanctioned by Sir Astley Cooper, Mr. Key, and Mr. Bransby Cooper.

To quote from the Reports for '38 and '39—"Yet there are cases in which this complaint produces so much pain of body and mental distress as to render it absolutely necessary to do something more than is generally advised."

The mode of performing the operation is as follows:—"The patient being placed in the recumbent posture, the relaxed scrotum is drawn between the fingers; the testis is to be raised to the external ring by an assistant; and then the portion of the scrotum is to be removed by the knife or knife-scissors—but I prefer the former. Any artery of the scrotum which bleeds is to be tied, and a suture is then made to bring the edges of the diminished scrotum together."

Then follow four cases in which the treatment succeeded.

Mr. Key relates a case in which the wound granulated up, the result being all that could be desired.

In one case a ligature was employed instead of the knife, but the pain and constitutional irritation were more "than the complaint justifies."

Mr. Cooper reports a case with the following comment:—

"It appears to me, however, and, indeed, seems apparent, from the daily report of the above related case, that the excision of a portion of the scrotum leads to the cure of spermatocele, by inducing inflammation and consequent obliteration of the diseased veins, and without the same risk as attends the application of any immediate means to the veins themselves, as must be the case either by the employment of a ligature or the excision of the varix."

ON PERICARDIAL ADHESIONS.

(Free and abridged translation from a paper by Dr. Tuczek, of Cologne, in Berl. Klinische. Wochenschift.)

The diagnosis of pericardial adhesions may be said to have lost rather than gained by recent investigations, since all the symptoms of the condition hitherto observed, with the exception, perhaps, of the simultaneous occurrence of systolic drawing-in of several left intercostal spaces and the diastolic collapse of veins, described by Friedreich, have been shewn by careful observation to be often absent in cases of complete adhesion of the pericardium, and frequently to be present where no such adhesion existed.

If, therefore, the diagnosis of complete adhesion is, on good authority, not always possible, the positive statements of so many authors that lesser circumscribed adhesions of both layers of the pericardium do not admit of diagnosis, must be taken at least *cum grano salis.*

I am prepared to show by the following case that, under certain circumstances, a single short band of adhesion is sufficient to give rise to unequivocal symptoms. It is to be expected that, when a cord-like adhesion is continually limiting and obstructing the natural locomotion of the heart's apex during the

systole, that certain alterations should be manifest in the heart's impulse. That impulse will be weakened, or altogether absent, or a drawing-in of the intercostal space may take place.

Further, even an apparently slight adhesion may lead to dilatation of cavities and all its subsequent effects, since the energy of the heart must be always more or less strained when subject to a constant check of this nature.

In one case the adhesion was narrow and cord-like, and had for its only obvious symptom a weakening of the heart's impulse, from which the diagnosis was made. Weakness or complete absence of the perceptible impulse of the heart may be due to so many causes that it can only be taken as diagnostic of pericardial adhesion where it exists in the face of numerous direct indications for an *increase* of such impulse, and only in such cases is it possible to define approximately the seat of such an adhesion.

Our case bore these relations, and may be shortly stated as follows :—

P. K., æt. 60, admitted January 8th, suffering from dyspnœa, præcordial distress, and sleeplessness. Patient was slightly cyanosed in face, jugular veins dilated but not pulsating, some œdema of feet. Pulse full, hard, regular, synchronous in carotid and radial arteries, and equal in both radials. Signs of slight bronchitis in both lungs. *Heart.*—Apex beat *imperceptible*; diffuse vibration in fourth and fifth left intercostal spaces, both perceptible and visible. Dulness a little increased to the left side, and very marked over manubrium and to either side of it for half an inch. Diastolic bruit audible at apex, but heard most clearly to the right of the lower end of the manubrium, where it was preceded by a short systolic murmur: audible also over carotid arteries. Liver somewhat enlarged.

On January 18th, signs of pneumonia at the right base became apparent, and a few days afterwards distinct pulsation in jugular veins and in liver.

On January 28th, a very weak cardiac impulse perceived in sixth interspace.

The following diagnosis was recorded :—"Dilatation of ascending aorta, with circumscribed adhesion of both layers of pericardium."

Death took place on February 1st.

P.M. examination showed the heart to be free within the pericardium, with the exception of a single band of connective tissue, about three-quarters of an inch long, which, springing from the left ventricle just above the apex, was attached to a spot above and to the right on the parietal layer of the serous membrane.

The remainder of the diagnosis was also fully confirmed.

It is probable that such adhesions as the above may not be uncommon, and may admit of diagnosis. Their favorite seat would appear to be in the neighbourhood of the apex of the heart, possibly owing to the fact that that point is subject to the least change of position, relatively to the pericardium, in the rythmical movements of the heart.

I should like further to draw attention to an observation on the subject of which, so far as I am aware, no mention has ever yet been made, viz., on the expiratory weakening of the heart's impulse as a sign of adhesion of the border of the left lung to the pericardium.

The relation of inspiration and expiration to cardiac dulness has been fully studied, but, hitherto, no attention has been devoted to the influence of these acts upon the heart's impulse. Physiologically the heart's impulse becomes weakened during inspiration by these causes :

1st.—The deep position of the diaphragm.

2nd.—The interposition of lung tissue between the heart and the chest wall.

3rd.—The lowering of arterial blood pressure.

If from any cause either of the above should be absent or altered, there may be produced more or less alteration in the intensity of the heart's impulse ; but, where the physiological condition is exactly reversed, the pericardial adhesion has, in a great number of cases, been correctly diagnosed.

In one case (æt. 74) a cord-like fibrous adhesion, between the border of the left lung and the outer and lower side of the pericardium, was discovered.

In another (æt. 22), marked weakening of the cardiac impulse was observed on expiration ; but, on the occurrence of left pneumothorax, by opening of a pre-existing vomica, the impulse was found to be equal under all circumstances. In this case the pericardium was found to be firmly adherent to the border of the left lung.

I wish only further to point out how frequently one may observe in phthisical patients, in whom the occurrence of inflammation of serous membranes is common, the commencement of this pericarditis extema, which lays the foundations of such adhesions.

CASE OF AORTIC ANEURISM OPENING INTO POSTERIOR MEDIASTINUM.

Thomas A., æt. 40, was admitted into 13 Stephen, under Dr. PAVY, June 20. A waterside porter ; work is very heavy and he is frequently exposed to wet and cold. Family history good. Has always enjoyed excellent health until twelve months ago, when he began to complain of cough and pain in chest. He became weaker and lost flesh to some extent. Three months ago cough became severe, and he had much dyspnœa and expectoration, with severe pain in back and about epigastric and hypochondriac regions. These symptoms have continued until admission.

On admission.—Is a much wasted man. Some pain in deglutition, referred to lower part of sternum.

Takes food slowly and in small pieces, otherwise experiences a choking sensation. Has a pretty severe loose cough, and some dyspnœa. Sputa profuse, frothy. Chest well formed and expands well. Deficient resonance in right infra-clavicular region, with bronchial breathing, and especially prolonged harsh expiration. In left infra-clavicular region breath sounds are somewhat bronchial. Behind, breath sounds are harsh all over. Moist sounds are audible all over chest. Heart dulness normal Apex beat in fifth interspace, in a line with nipple, forcible, and heaving to some extent. A loud rough systolic bruit is audible at the apex and over præcordial area as high as third interspace, where it abruptly ceases. It is not audible in axilla or behind. No bruit heard in umbilical region. Over the fourth, fifth, sixth, and seventh left ribs, internal to mammary line, is some bulging, and the same area is elevated with the cardiac impulse in a marked manner. Pulse feeble, large, regular, easily rolled under finger.

Patient complains of much dull pain in epigastrium and hypochondria as well as in dorsal region. Usually walks about ward in a slightly stooping position with one hand pressed upon back.

Ordered ℞ Spiritus Ammoniæ Aromat ʒ s. Tinct. Scillæ ♏xx. Tinct. Senegæ ʒ j. ex. Infus. Senegæ ʒj. terquotidie.

June 29th.—Somewhat easier. Has less cough and expectoration, but eats little, and has vomited several times during the last few days. No alteration in physical signs.

July 6th.—Losing strength rapidly. Appetite bad. Pain in back more severe. Cough troublesome. Much nausea and flatulence and occasional vomiting. Bowels confined. ℞ Pulv. Digitalis gr. j. Pil. Scillæ co. gr. iv. Fiat Pil. b.d. ℞ Mist. Ammoniæ ʒj. 6 tis horis.

July 19th.—Is losing flesh steadily. Cough is somewhat easier, but worse after drinking. Appetite bad. A good deal of pain in deglutition, referred to lower part of sternum and epigastrium. Elevation of chest wall somewhat more evident. Moist sounds in chest disappearing.

July 30th.—Symptoms principally gastric. Breathing is fairly easy and he has but little cough. Bowels obstinately constipated. Appetite bad. Pain in deglutition increased. Almost constant nausea. Much epigastric pain. Pain in back less. ℞ Bismuth Subnit. gr. viii. Mag. Carb. gr. xv. Pulv. Cinnamonii co. gr. viii. ex. Aq. Camph. ʒj. terquotidie.

August 1st.—Died at noon. Was walking about ward, suddenly became faint, pallid, and almost pulseless, lost sensation and power in extremities, and died quietly in about an hour, apparently from syncope.

Autopsy.

Pleuræ extensively adherent. Lungs œdematous, but otherwise healthy.

Posterior mediastinum.—Contained a considerable quantity of black blood, which also extended along the aorta, below the diaphragm, to some extent. A large aneurismal sac had been opened, which lay along the spine from the sixth dorsal to the first lumbar vertebræ, eroding them extensively. Some of the affected vertebræ had their cancellous tissue exposed, others had an irregular, white, fibrous layer covering it in. The aneurism involved the whole circumference of the aorta, and interrupted it for a length of five inches, the vessel opening into the pouch above by an oval aperture, and emerging from it below by a similar opening. The anterior and lateral walls of the aneurism were much deformed by chronic arteritis, and presented a peculiar transverse marking (like Linear atrophy of the skin) the result of stretching. Above and below the aneurism the aorta was fairly healthy, presenting only a few patches of slight atheroma.

Heart.—Weight, 10 ounces; muscular fibres soft and flabby, otherwise healthy.

THE COLLEGE.

A brief mention was made in our last number, of the proposed new college to be attached to the hospital, and a hope expressed that the idea would be soon consummated.

This month we have to regret that the further consideration has been postponed for a year.

All know that the Hospital and School are two separate institutions; their internal arrangements and monetary matters being under different control; the former is managed by the Treasurer and Govenors, under the supervision of the Charity Commissioners; the latter is a private speculation originated and maintained by the Hospital staff; the former lacks but little pecuniary assistance beyond its endowments, the latter has no endowments whatever and possesses but little, living as it were from hand to mouth.

Now, as the College building would be a speculation on the part of the school authorities, it would be from them that the necessary capital would have to come; and it was their wish we understand, the hospital authorities consenting, to borrow the necessay amount from the hospital funds at 4½ per cent. interest, to this the Charity Commissioners objected, maintaining that the Hospital had no guarantee for the payment of the interest or the return of the capital.

Thus has the project fallen through until other measures have been taken to provide for the necessary outlay. It has been proposed to build the college on a less expensive and consequently less extensive scale, but we hope that if the thing is to be done at all, it will be done properly and not niggardly, preferring rather to wait a year so that the original idea may be carried out.

The original plan was to occupy the space left vacant by the pulling down of the Maze Pond Chapel, at the same time removing the three or four small cottages abutting on New Street, and the large black wooden building at the back. On this large site a somewhat quadrilateral building was to have been built, extending from Maze Pond, to Maze Pond Court, rather handsome in design according to the plan shown to us. In the centre was to be a square court yard, in which the common dining hall and kitchens would be placed. Rooms; a sitting and bed room would be sufficient for between forty and fifty students.

That the project has for the present fallen throughwe can only regret; but hope that no questions of economy will induce the authorities to moderate their scheme.

GUY'S HOSPITAL GAZETTE, *SEPTEMBER*, 1877.

ERE another number of the *Gazette* appears the Session of 1877-78 will have commenced. Many Guy's men will have left us for other spheres, and many, whom at present we know not, will have taken upon themselves the honoured name and duties of a Guy's man: to the former we wish Godspeed and every success; to the latter we hold out the right hand of fellowship, and bid them welcome to take the place of those departed and support the honour of their school.

Guy's, alas! has for long borne too bad a name among the general public, thanks to a certain class of novel writers and the *Police News*; and we look to our successors to help us to carry on the good work of living-down the opprobrium cast upon us, and by their conduct give the enemy no cause for complaint.

What to do, and how to do it, is the question of every first year's man. The Introductory Lecturer—at Guy's, thank goodness, a thing of the past—gives good wholesome grandmotherly advice, which we fear is but little heeded. The General Medical Papers give us what they call a "Students' Number," which, consisting as it does of an incongruous mass of facts badly and loosely strung together, is but little read, and certainly but little to be understood. Our contemporary, *The Students' Journal*, certainly seems to have gone about the right way to teach the young idea; but, it seems to us, that as each hospital course differs in many respects, these *general* instructions can never be of much use or real value, so we hope next month to see what we can do in this way by giving to our readers some "Hints to First Year's Men."

Their first formal introduction to Guy's will be at the Annual Conversazione, which is to be held on the evening of the 1st of October, in the place of the old established Introductory Lecture, an improvement that few will care to deny, who were present at the very enjoyable evening of last year—an enjoyment that, we believe, will be enhanced this year by the presence of the fair sex. In what part of the hospital it is to be held has not as yet been decided, but we hope that ample room will be allowed, especially as ladies are to be present, thus doing away with the unseemly and uncomfortable crush of the last occasion.

CASE OF PYÆMIA FOLLOWING OSTEO-MYELITIS.

Communicated by H. DAVY.

The following case is of such rarity as to be worth recording at some length. The pecularity of the rash baffled all the students who saw it: and many of those, who had had special small-pox and scarlatina experience, were quite uncertain whether the case was one of either of these diseases. It is true that the diagnosis made by the staff in charge (Mr. JACOBSON and Dr. GOODHART) was proved by the post-mortem examination to be quite correct; but, had the case occurred to any of us students, who had never before seen a case, we are certain that it would have been to us one of the greatest difficulty.

General history.—Patient came from the Greenwich Industrial School, and is an orphan. He is much marked with small-pox, which he says he had eleven years ago; we could get no reliable account of any other illness.

History of present attack.—On August 9th, four days before admission, he fell down whilst walking along the street. He says that, before falling, he had a headache; but he does not give any clear history which will enable one to judge whether he had a fit or not. He was picked up and helped home, and the next day attended at the Guy's Surgery with some symptoms of synovitis. He came up to the surgery, on the 13th, seeming ill and complaining of pain about the left knee and leg, which he had injured, or is supposed to have injured, when he fell. There being merely symptoms of synovitis in the left knee, with œdema of the left leg, the patient was sent, under Mr. Howse, into Naaman (it being his casual).

He was admitted about 4·15 on 13th, and from the senior house-surgeon the following was then his condition:—

"Patient seemed very ill, with a furred tongue, and quick, small pulse. His left leg was much swollen from the knee to the ankle, and was very œdematous, pitting much on pressure. The skin, for the same extent, was a bright red; and the temperature over the same was raised. Just below the knee the leg was very tender to pressure, the tenderness extending down the leg for a short distance. The left knee seemed to contain fluid, but in small amount. Extending up the thigh, for a short distance above the knee, was a bright red rash with a well defined margin. About half an hour after admiss on patient was put to bed, and nurse then noticed a patch of rash over the *right* buttock and *left* shoulder. Soon after this she gave him some tea, which he brought up, the vomit being stained with blood."

I saw him about three hours after admission. He was then very ill, and rambled in his talk. His tongue was covered with a thick dirty white fur, and his pulse was small and beat 140 to the minute. His temperature was 103·2°, and his respiration 40 to the minute He had several times been sick. On examining his body all over we found the left leg much in the same condition as we have described; a red rash similar to that now to be described extended up the thigh, especially on the inner side. A large patch of rash was found over the right buttock, and a similar one over the left shoulder. There was then no rash over the back; but on the abdomen, a little

below and to the left of the umbilicus, were two small patches about the size of a shilling. There was a large patch of rash on the right arm near the elbow, and the face had a mottled appearance, especially about the forehead. These patches had all the same characteristics. They were raised above the level of the skin, and faded on pressure, to re-appear as soon as this was removed. They were of a deep pink or rose colour, and had very well defined margins. They seemed to itch, for patient kept on scratching them, but they left no wheal when a pointed instrument was drawn across them.

Two hours after this the characters of the rash had much changed. The patient's back was nearly covered with a rash, which had partly the characters which we have described, but which passed gradually into an erythema, without that definiteness of margin which we have spoken of. The skin was for the most part of a red-pink, with here and there more patchy spots. The redness had extended up the thighs and become more erythematous in character, whilst the other patches we have mentioned have extended, and at the same time lost their defined margins. Patient's condition was worse and he was more restless. Pulse, 150; respiration, 46; temperature, 102·4°.

Two hours later the patient's body was covered with an erythematous rash, which fades on pressure, and is at parts still patchy, *i.e.*, is raised, and has at this part a defined or semi-defined margin marking it off from the rest of the rash. His throat was somewhat injected, and he said was sore, but no enlargement can be found externally. He was very restless: often sick; his pulse very small, and beat 170 to the minute. The left leg seemed somewhat less tender to pressure.

August 14th.—9·30 a.m.—Patient's whole body was now covered with a dusky red rash, which was not raised above the level of the skin, and which faded on pressure. This rash had much the characteristics of that found in the semi-malignant forms of scarlatina, which kill so quickly; but, with the exception of slight injection of the tonsils and fauces, the throat was normal. The tongue was covered with a thick dirty white fur. His temperature is 103·2°; pulse, 146; respiration, 62. He was quite delirious and very restless, and was also unable to keep anything down. His left leg was in the condition we have described.

August 15th.—12 noon.—Patient's condition was much the same, but two small petechial spots have appeared on the abdomen below the umbilicus. There seemed to be a small amount of fluid in the joint and around the head of the tibia.

2 p.m.—Mr Jacobson cut down on the tibia, just below the left knee, under the spray. The incision was about two inches long, and a small quantity of pus escaped. He then incised the knee joint on both sides, and passed a drainage tube through the joint, when a small amount of pus escaped from the outer side. He found the surface of the tibia rough, and the ligamentum patellæ sloughing.

4 p.m.—The rash had assumed a still more dusky hue. Patient was very delirious and could only with difficulty be kept in bed. Pulse just perceptible, quite unaccountable. Throat injected. Tongue as described. At this time I passed an india-rubber catheter and got a small amount of urine, which contained no albumen. Patient continued to get worse and worse, the rash became more dusky, the breathing more laboured, the delirium increased, and at last patient died at 9·30 p.m.

August 13th.	Temperature.	Pulse.	Respiration.
8 p.m.	103·2°	140	40
11 p.m.	102·2°	140	40
August 14th.			
10·40 a.m.	103·2°	144	41
1·50 p.m.	103·6°	144	42
4·30 p.m.	103·4°	160	60
5·35 p.m.	103·4°	uncountable	64
7·45 p.m.	103°	,,	,,
9 p.m.	108°	,,	,,

Shortly (ten minutes) after death his temperature was 104°.

At post-mortem examination:—

The *brain, heart, liver, kidneys, spleen, small intestine, testes, bladder,* and *urethra* were found to be quite normal.

No source of mischief could be found about the *teeth or head.*

The *larynx* was healthy.

There was marked ecchymosis of the *left lung,* but no softening patches reached the surface. In the deeper surface was found one patch, sloughing into an abscess, with a well defined purple margin.

Lymph was found along the edges of the *right lung,* and several wedge-shaped sloughy patches were to be seen on its surface.

Some amount of acute pleurisy existed on both sides.

All the large joints were examined and found to be healthy, except the left knee.

The ligamentum patella was found to be sloughed through, and a little pus was found in the connective tissue over the int condyle outside the joint. No pus was found in the joint. The upper part of the *left tibia,* corresponding to the ligament, was found to be roughed, and, on cutting into the bone, all the characters of osteo-myelitis were found.

NOTES OF CASES IN MR. HOWSE'S WARDS.

An attentive watching of the cases in these wards will convince every one, who choses to examine the subject without prejudice, of the great value of *antiseptic dressings.* Not only is traumatic fever nearly unknown, and that even in cases which have undergone severe operations, but the general character of the discharge is *far* more uniformly healthy and free from smell than is seen with any other kind of dressing.

It is manifestly absurd that any system should be severely criticised, or even laughed at, by persons altogether ignorant of its details, or by those who will not take the trouble to examine its practical results. Hence, we strongly advise our fellow-students to use the great opportunity afforded at Guy's for examining the working of the antiseptic and ordinary systems side by side. If this is done we have little doubt but that antiseptic surgery will take yet more rapid strides towards universal adoption than it is even now doing, although this seems hardly possible when we reflect that at the present moment it is adopted at Guy's by every dresser (without exception) who is allowed by his surgeon to do so.

Turning to our cases—

1.—Excision of the knee has been performed on the patients in 4, 8, and 13, Naaman, and in 7, 11, 15, and 22, Dorcas. Examination of these cases will show the result of the operation in most of its stages. The reports will prove that in every case the constitutional disturbance has (with one exception, which had a high temperature for three or four days) been *absolutely nil.* Brilliant success followed the operation, 8 Naaman, 7, 15 and 22 Dorcas, in one of which (15 Dorcas) the disease was so far advanced that most surgeons would have at once amputated. The mode in which these cases are put up in wax is well worth study.

CASES IN NAAMAN.

No. 17 proves with what success excision of the ankle can be done, if that operation is preferred to the ordinary ampu-

tations of the foot. Old sinuses existed about the ankle, leading to carious bone, and the patient's temperature on admission was 103·2°. A few days after the operation the temperature was 99·6°, above which it never rose, and for a long time past it has been normal. The wounds are now all but healed, and the foot is in capital position. The splint, designed by Mr. Howse, keeps the foot in beautiful position, and allows it to be dressed antiseptically without trouble.

No. 9 is an interesting case in which the head of the humerous was excised. Patient, æt. 9½ years, was quite unable to lift his hand to his head, and the movement of the arm was in every way most limited. After various treatment for nearly six months, it being found that the muscles responded to electricity, the head of the humerous was excised. At the operation it was found to be much diseased, the articular cartilage being in parts quite eroded. An abscess, deep in the anterior flap of the axilla, was also opened and the caseous pus evacuated, after which it was found to communicate with the joint. The whole operation was done with every antiseptic precaution, and there was *no* constitutional disturbance. By means of strapping, a weight, and pulley, the arm was kept at right angles to the body. The wound is now mostly healed, and patient gets about the ward and grounds, keeping his arm to the side; at night extension is put on. It is well worth watching the case to see what amount of motion will be obtained.

CASES IN DORCAS.

No. 5 is a case of excision of the elbow, in a child æt. , for long standing strumous disease. She had attended at Out-patients for some time, and dead bone had been felt about the lower end of the humerous through the sinuses. At the operation it was found that nearly the lower third of the humerous was necrosed, and small pieces of dead bone were removed, leaving a considerable cavity in the bone. There has been no constitutional disturbance, and the case seems doing remarkably well and is granulating up, the granulations being on a level with the skin. It remains to be seen whether all the dead bone was got rid of, and what amount of motion is obtained.

No 6. In this patient the left thigh was flexed on the pelvis and immoveably fixed by anchylosis following old standing hip joint disease. Subcutaneous osteotomy was performed, a chisel being used and inserted through a small incision. It was done under the spray. The superficial incision healed by primary union, and the leg is now beautifully straight. It was treated merely by extension kept up by a weight and strapping in the usual way.

No. 19. Patient, æt. 5 years, has had marked rickets leading to hideous deformity of both legs. The bones being consolidated, Mr. Jacobson (for Mr. Howse) divided one tibia. and, having straightened the leg, did it up in a metal splint with wax bandages, in much the same way as we treat excision of the knee. A transverse incision was made down to the tibia, which was then partially sawn through; after which the bone was fractured, and the leg easily became straight. The result promises complete success, and a comparison of the two legs (the other is to be subsequently operated on in the same way) will show how desirable the treatment was.

PYREXIA AND METHODS OF REDUCING IT.

Second Prize Paper (equal) read before the Physical Society, 1876-77.

BY CHARLES KNOX SHAW.

Mr. President and Gentlemen,

I am afraid it is scarcely possible for a student in his fourth year to start any fresh or original theory as to the origin of fever, so that the paper this evening will be more or less "on Authority." Before I begin, I should like to say a few words as to my method of pursuing the subject.

The paper will be mainly divided into two parts: the first will be taken up with a discussion of the most interesting points connected with Pyrexia, including the theory of the cause of Pyrexia, increased combustion of tissues and increased production of heat, the changes produced in the tissues and the natural methods of the elimation of heat.

The second part will consist of a review of several of the methods of reducing the high temperature. For I think it is now universally acknowledged that it is the high temperature in febrile diseases that is most to be feared.

As far back in the history of medicine as we choose to go, we shall find that there have always been two distinct and opposed theories to explain the phenomena of fever. One side insisting that the blood was primarily affected; the other that fever was primarily caused by derangement of the nervous system.

My paper may be objected to from the very beginning, because, I start by taking a disputed hypothesis as sufficiently enough proved to found a theory of fever: namely, that for specific febrile diseases there is a distinct and separate specific poison, that originates outside the body and by some means gets into the blood. Thus in typhoid fever there is a certain fermentative process set up in the body by an organism whose origin is not yet certainly fixed, but of whose existence there does not seem to be much doubt.

I need scarcely say that fever consists of increased heat of the surface of the body, accompanied by accelerated pulse, loss of appetite, thirst, languor, debility, unwillingness to move and general disturbance of all the functions. But the two most constant symptoms of fever are, an increase of pulse and increase of temperature.

Niemeyer says, "the elevation of the temperature of the body in febrile diseases, depends upon an abnormal generation of heat from a morbidly active combustion of the constituents of the tissues in which of course the nitrogenous elements participate."

The question we have now to consider is, what causes this morbidly active combustion?

Is it due to some disorder of the nervous centres, causing paralysis of the vasomotor and sympathetic nervous systems by which their regulative power over the animal heat of the body is disturbed?

Or is it due to some poison which is acting immediately on the blood and tissues, and that the systemic disturbances are secondary?

Most upholders of the first theory would allow that this vasomotor disturbance was primarily caused by the poison above alluded to.

If this is not the case one does not see what would suddenly cause this disturbance. Even if one were to believe in that rather improbable theory, that there is one particular centre in the brain which becomes paralysed, there must be something to paralyse this centre.

But first is it a settled question that animal heat is regulated by the nervous system? If it is not we are then grounding a doubtful theory upon a doubtful basis, but I am afraid we must do this in any case.

Cases are brought forward in which there is a considerable rise of temperature after injuries to the spinal cord or other nerves. But these facts do not prove anything, in the first place because there is scarcely any similarity between the pyrexia produced by these nerve lesions and true febrile pyrexia. Secondly, because a great number of cases of similar injuries could be brought forward in which careful observations have shown that there was a considerable lowering of the temperature.

One of our senior physicians, Dr. WILKS, states that the increase of temperature in lesions of the nervous system is not equivalent to fever.

Besides heat caused by excessive tissue dis-integration, which I hope, later on, to show you is the case, Wunderlich says "It is not at all impossible, that independently of the oxygen in the body, some kind of fermentative process may be excited, which may become a fresh scource of heat, as indeed happens external to the organism (as also perhaps in zymotic diseases)."

It is a well ascertained fact that an injection into the blood of any of the following substances will set up a state of fever, and they are consequently said to have a pyrogenous acti n in the blood: the injection of fresh pus, pus serum, leucin, sulphurated hydrogen, sulphides of ammonium, and carbon, decomposing vegetable matters and others.

Senator of Berlin and other patho ogists have used these methods of inducing fever, in order to carry out their investigations upon this subject.

In Holmes' Surgery there is a very clear description of the cause of surgical fever; the gist of which is this, that there is a feverish state set up by the blood circulating through an inflamed part, and that the blood is also poisoned by the inhibition of some pyrogenous material.

I should like you to carry these facts to the medical side of the house, and we should find, I think, that the two kinds of fever we meet with there, are analogous to the two kinds of surgical fever above mentioned.

As an example of the first kind I may instance pneumonia, which is a local inflammation of the lung, which heats the blood passing through it so much so that it cannot be eliminated by the skin and lungs, and thus a pyrexial state is induced. As an example of the second variety we may take the specific fevers in general.

In fever as must be obvious to all, the body wastes, we can tell this not only by looking at the patient as he lies in bed, but also by scientific chemical investigation.

In health the discharge of nitrogen in the excreta is exactly counterbalanced by its introduction in food.

If a person is found to be discharging a greater quantity of nitro-genous matter than he is taking, he must be using some of that which his frame is composed. Now fever patients do this. A person in health and taking an ordinary amount of nourishment excretes about 500 grains of urea per diem.

It was thought that a comparison between the urea excreted by a person in health and by a fever patient would scarcely be trustworthy, unless both were placed under as nearly as possible similar conditions. It was then found that a person lying in bed and taking fever diet (slops), only excreted 270 grains per diem, but a fever patient is said to excrete three times as much urea as a healthy man on fever diet. Besides the increased urea showing tissue change, the amount of carbonic acid given off is increased two and half times.

Mr. West says, "The percentage of urea during fever (1) is high and remains fairly constant as long as the fever lasts; (2) does not follow the slight variations of temperature; (3) does not vary with the volume of the urine; (4) it shows oscillation with changes in diet; (5) it falls with the termination of the fever."

I should say that Dr. Sidney Ringer and Dr. Squarrey have both brought forward cases which show that it is not the pyrexia alone that causes the increased secretion of urea.

Dr. Ringer observed that in ague the increase of the urinary discharge of nitrogen, not only begun some time before the accession of the cold stage, but even preceded the rise of temperature. This fact seems to be borne out by the result of experiments made by Senator of Berlin, who injected pus subcutaneously into dogs, and found there was an increase in the discharge of the urea before the temperature rose.

Dr. Squarrey showed from eighteen carefully observed cases of typhus, that the daily rate of discharge of urea although usually above the normal during the first weeks, did not attain its maximum until the temperature had been falling for some days.

Increase of bodily temperature may depend on two thing; either there is less heat given off, a normal amount being produced or there is an increased production with a normal loss of heat.

Physiologically the production of heat depends on the oxidation of the constituents of the body, and consequently increased oxidation would be followed by increased production of heat.

Physiologically also the excretion of urea is stated to be due to the contribution of the nitrogenous elements in the tissues.

In fever, as shewn above, the amount of urea excreted is usualy increased and the bowels rapidly wastes, and this and others careful experiments, into which it would be tedious to go, are considered strong proof by Senator Webb, Liebermeister, Schneider, Leyden, Bilroth and others, "that in fever the consumption is gr atly increased, and that consequently mere warmth is barely produced than in the normal state, more than can be disposed of by the body in the same time."

In fevers of proportionately short duration, the dangers from increase of bodily temperature, is of course more to be feared than that accompanying the increased production of heat.

It is to be expected that this morbidly combustive process would produce changes in the organs of the body, we shall find that they are all more or less affected by it.

First on the Liver; the organ is diminished in size and rendered soft and friable. The right lobe being said to be more changed than the left; its cells are granular and swollen, occasionally fatty particles are observed in them; in some cases the condition obscures the nucleus.

In advanced cases the cells break down and form a granular debris, which, should recovery take place is supposed to be absorbed.

In the kidneys the malpighian bodies and pyramids are very vascular. The changes in the epithelium of the tubes are similar to those described, as in the liver cells. These changes give rise to the albuminuria so often observed in pyrexia, they are precisely similar to those met with in the earlier stages of Tubal nephritis. Some pathologists describe a swollen and granular condition of the alveolar epithelium of the lungs. The increased combustion of tissues alters the composition of the blood as well as the structures of the other tissues.

Dr. Wickham Legg produced precisely similar changes in the organs of animals by submitting them to a high temperature.

There is a fatty degeneration of the walls of the smaller blood vessels, and it is asserted by some of the best of authorities that there is a granular and waxy degeneration of the voluntary muscular fibres, and amongst them those of the heart. So that it would seem that the loss of muscular power observed in cases of pyrexia, may be due not only to disturbances of the cerebral nervous organs, but to this degeneration of the fibres preventing proper muscular contractions.

The degeneration of the muscular tissue of the heart, leads to numerous complications by seriously diminishing its propulsive action.

This impairment of the hearts action causes changes in the pulse, after some duration of fever we find that the artery is soft and relaxed, is easily compressible, and its dichrotism can be made out by the finger. There is a diminished circulation and consequently congestion of the nervous system, diminished secretion of urine, and general œdema of the lungs.

The above phenomena are, no doubt partially due to the fatty change in the walls of the blood vessels.

If the heart's action is weak there is a coldness of the hands and feet, and sometimes of the face.

The pulse in a febrile attack corresponds to the temperature in its daily rise and fall,

The changes brought about in the brain by the high tem-

perature, have not been very thoroughly investigated, but in the majority of cases examined there have been found more or less adhesions of the dura mater to the calvarium with œdema of the membranes of the brain. Buhl declares that the cerebral disturbances observed in fever are consequent upon this œdema.

The microscope reveals a pigmentary deposit in the ganglion cells, and fatty degeneration of the nerve fibres of the brain, corresponding probably to the parenchymatous degenerations of the other organs.

Liebermeister recognises four different degrees of febrile disturbances of the nervous system due to pyrexia. The first degree consists of general malaise, restlessness, headache, and unquiet sleep. These symptoms are usually observed at the commencement of a febrile attack.

In the second degree there is apathy, blunted sensations, failure of memory, and the patient if not thinking of himself becomes delirious.

A muttering and occasionally violent delirium with great restlessness, and a condition of stupor from which it is difficult to rouse the patient marks the third degree.

The fourth and last degree is the most fatal one, the patient is unconscious and lies without any evidence of mental activity. This degree corresponds to an almost complete abolition of the functions of the cerebrum, and when this paralysis extends to the medulla oblongata, it leads to death.

That most of the urea formed in fever is eliminated by the kidneys is a well established fact, but Dr. Murchison thinks that some of it is sometimes retained in the blood, and then gives rise to these symptoms of urœmic poisoning, occasionally observed in the later stages of the continued fevers.

Dr. Murchison does not deny the view upheld by Liebermeister, that the brain symptoms are due to defective nutrition of the cerebral organs, but he bases his statement on the following facts:—that in some cases of typhus, and relapsing fever with severe head symptoms, which he examined no lesion was found in the brain or its membranes; but that in several cases urea was detected in the blood, and also that a diminution of the quantity of urea in the urine usually preceded these head symptoms.

The true dangers of pyrexia consists in "the deleterious influence of a high temperature at the tissues," causing as it were a "wearing out" of the same, paralysis of the heart being the first danger, then paralysis of the brain, and finally disturbances in other organs.

Knowing as we do that the above serious complications will necessarily follow a high temperature, we are, I think, fully justified in using any means with which we are acquainted to keep the temperature in abeyance.

(To be continued.)

REVIEW.

HINTS ON OPTHALMIC OUT-PATIENT PRACTICE. BY CHARLES HIGGENS, F.R.C.S.

Often does one hear general practitioners who have been in practice some years complain bitterly, that they did not in their student days pay more attention to the study of *diseases of the eye*,—a complaint that is frequently echoed by the consulting opthalmic surgeon, to whom the case comes at last, perhaps too late, when if taken in time and at its commencement, the disease might have been easily managed by some very simple treatment.

To their notice, as well as to the notice of present students, would we recommend heartily the perusal and study of this little book; the lessons which it teaches could be easily mastered by an hour's careful reading, which it would most amply repay.

In eight short sections Mr. Higgens treats of most of the common affections of the eye one meets with either in Hospital or Private Practice.

In the first section, he treats of the various forms of Ophthalmia, briefly referring to their differential symptoms, and giving the treatment which his vast experience at a large Hospital as Guy's has shown him to succeed best in each. In the same method, Photophobia, Iritis, and Glaucoma, diseases of the eyelids and Epiphora, are treated in Sections II. III. IV. and V Sections VI. and VII, we would particularly recommend to the reader's careful perusal, dealing as they do with abnormalities of vision, and the use of the ophthalmoscope. In the former section the various abnormalities of refraction, Myopia, Hypermetropia, and Presbyopia, are discussed, their diagnosis and treatment are clearly set forth and very lucid are the directions given to find the suitable glasses. Section VII. is the longest in the book, and explains in simple language the way to use the ophthalmoscope, and the appearances seen in the healthy and morbid eye. It is a chapter that all should know by heart who would be perfect in the examination of the eyes.

The last section refers to the treatment of injuries to the eye, whether due to the presence of foreign bodies or to wounds, and ends a book which, compressing as it does into a small space, the sum and essence of the larger manuals on ophthalmic surgery, will form a first-rate introduction to their study.

That the first edition was so scarce and so frequently sought for, was a good indication as to the necessity of such a book—a book that will confirm if not increase the author's reputation as a teacher and ophthalmic surgeon.

Our space precludes us going more into detail with relative to the excellence of this little work; but, we should be glad if our notice of it should prove an incitement to any, thus to renew or improve their acquaintance with the study of ophthalmic surgery.

A SEQUEL.

In our last we directed attention to a case in Samaritan of Scrotal tumour, which was described as "Chronic orchitis, with abscess and probably a hydrocle." At the patient's urgent request the testicle was removed and presented the following appearance:—The testicle and *tunica vaguicles* were fairly healthy; the *globus minor* was about an inch in diameter and caseous, it communicated with an abscess which had previously been opened. Between the epididymis and testicle there was a cyst, capable of containing about 2fl. oz., its interior was lined with a port coloured fibrinous layer, the fluid in it contained numerous choler tearines, crystals, and granular matter. At its posterior post and completely embedded in the fibrin, was a cyst—largest axis ½ an inch, communicating with the *globus minor* and filled with a milky fluid abounding in spermatozoa.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

EXAMINATION FOR THE LICENCE (SECOND PART, OR PASS). JULY, 1877.

MATERICA MEDICA, AND CHEMISTRY IN ITS APPLICATIONS TO PATHOLOGY, PHARMACY, AND TOXICOLOGY.

1. Enumerate the remedies used to reduce the Temperature of Fever. How would you employ them?

2. Give the physiological action and therapeutic uses of Conium.

3. Give an account of the action and uses of Anæsthesiant Remedies, both general and local.

4. Give the action and uses of the Oxyde and Nitrate of Silver.

5. *Explain in detail how you would prepare a strong* solution of Ammonia, and express by symbols the reaction which occurs. From a pound of Sal Ammoniac what weight of Ammonia Gas can be obtained?

6. Describe one experiment which you consider proves satisfactorily the composition of Water. What is the cause of the hardness of water, and by what tests would you discriminate between a hard water, a water polluted by sewage matter, and a water containing a small amount of lead?

7. What are the chemical properties of Arsenic, Arsenious Acid, and Arsenic Acid; how can these bodies be converted the one into the other? Describe how you would ascertain whether a sample of wall paper contained Arsenic.

8. How is alcohol obtained from grain? Explain the processes adopted for its preparation. What are the differences between "Alcohol," "Rectified Spirit," and "Proof Spirit"?

MEDICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF MEDICINE, INCLUDING THE PRINCIPLES OF PUBLIC HEALTH.

1. Describe the parts of the healthy Chest in which the resonance on percussion is diminished, and state the reasons of these differences in resonance at different parts.

2. Describe the condition of the Heart in advanced constriction of the mitral orifice, the symptoms produced by this condition, and the means to be adopted for their relief.

3. A woman, thirty years of age, ill for ten days, and feverish, complains of pain in the right iliac region, where, upon examination, are found tenderness and an obscure brawny swelling. Movement of right thigh produces pain. The bowels are confined, menstruation is regular, and the pulse is about 104. What are the probable causes of these symptoms? How would you discriminate between them?

4. What are the more common conditions of system in which free uric acid is present in the urine? In what manner would you manage a case of Lithiasis or Uric Acid Gravel?

5. In what diseases of the Brain does vomiting occur, and how would you recognise the cerebral origin of this ymptom?

6. Enumerate the more common impurities of drinking water, and state their effects upon health.

MIDWIFERY AND THE DISEASES OF WOMEN.

1. On the 20th April a woman presented herself complaining of intense abdominal and pelvic pain; involuntary dribbling of urine, but inability to empty the bladder in the usual way. There was a tense prominent swelling of the abdomen, marked by dulness on percussion, from the pelvis upwards to three or four inches above the umbilicus. She had not menstrated for three months; and within the last month had suffered two attacks of retention of urine which were relieved without surgical aid.

Write a brief commentary on this case, pointing out the means of arriving at a diagnosis, and the proper treatment.

2. What are the more common causes of retardation in the passage of the head through the pelvis after clearing the brim, and point out the means of arriving at the diagnosis of such cases.

3. What are the principal causes of hæmorrhage occurring during the third stage of labour? Give the treatment.

4. Define the anatomical seat of the inflammations which may occur after labour in the neighbourhood of the uterus; state the time at which they usually occur, and describe their terminations.

5. What are the symptoms which determine women suffering from cancer of the uterus to seek for medical advice? How do you establish a diagnosis?

APPOINTMENTS.

The following appointments were made at the last meeting of the Medical Council; to take effect during the months of September, October and November.

OBSTETRIC RESIDENTS.—Ewen (*Sept.*) Gardner, (*Oct.*,) Pickering (*Nov.*)

DRESSERS.—Hearnden, L. M B. Jones (Mr. Forster); Berry, Granger (Mr. Bryant); Giles (Mr. Durham); Mansell, (Mr. Howse).

CLINICAL ASSISTANTS.—Sheldon, Uhthoff, Davy, Meek, G. Mackern, J. Poland.

DRESSERS IN THE EYE WARDS.—Lowdell, Greene, Shaw, J. Collington, Instone, Pain.

MEDICAL WARD CLERKS.—Hawkins, Elliott, Keep, Fookes, Lungley, Sheek, Parke, Briscoe, Morse, Leigh, Walker.

ASSISTANT PHYSICIAN CLERKS.—Morgan, Keogh (Dr. Fagge); Wood, M'Crea (Dr. Pye-Smith); Wilkinson, Alexander (Dr. Taylor); Hart, James (Dr. Goodhart).

OBSTETRIC OUT-PATIENTS' CLERKS.—Creed, Wood, Baldwin, Griffith.

POST-MORTEM CLERKS.—Cock, Pilkington (*Sept.*); West-Jones, Phillips (*Oct.*)

ASSISTANT SURGEONS' DRESSERS.—Symons, Cross, Wood, Peskett (Mr. Davies-Colley); Howe, Pierson, White, Bovill (Mr. Lucas); Deane, Steele, Flanagan (Mr. Golding-Bird); Bryden, Austin, Morrison (Mr. Jacobson).

DRESSERS IN THE SURGERY.—Matthews, Maylard, Morse, Brett, Penny, Jones, Reynolds, Howell, Bayer, Crossley, Fuller, Downes, Crooke, Scott, Gosse, Cockell, White, Williams.

SURGICAL WARD CLERKS.—Matthews, Hine, Brockliss, Fuller, Crossley, Maylard, Howell, Cock, Davies, Gosse, White, Hitch, Scott, Sage.

DENTAL SURGEONS' DRESSERS.—Cockle, Alexander (*Sept., Oct.*); Fielding, Reynolds (*Nov., Dec.*)

AURAL SURGEON'S DRESSERS.—Bryden.

ASSISTANT SURGEONS' CLERKS.—Shorthouse, Luscombe,

PHYSICAL SOCIETY.

The following are the Presidents for the coming year—Messrs. R. Birdwood, J. T. Brett, F. C. Coley, H. Davy, J. T. Hinton, W. D. Hartley, P. Horrocks, W. Lane, M. Lubbock, G. Mackern, W. P. Reynolds, C. K. Shaw, J. C. Uhthoff, R. S. Wainewright, G. A. Wright.

Dr. Taylor having resigned the post of Honorary Secretary to the Society, Mr. C. S. Symonds has consented to share the office with Mr. Clement Lucas.

NOTES OF THE MONTH.

We would call the attention of old Guy's men in general practice, to the use of Chrysophanic Acid in Eczema, (in the proportion of one or two drachms of the acid to an ounce of simple ointment or cold cream,) and to the marvellous effects assigned to it by Mr. Chubb, of Torpoint, and would ask them to try it, in either acute or chronic cases, and give us their xeperience as to its power over the disease.

UNIVERSITY OF LONDON. First M.B.—The following Guy's men obtained honours in the above examination.

Anatomy.—2nd in First Class, T. W. O. Pughe.

Physiology, Histology and Comparative Anatomy.—Second Class, L. C. Wooldridge. Third Class, T. W. O. Pughe.

Chemistry.—First Class, W. H. White. In Second Class, L. C. Wooldridge, A. E. Maylard.

Materia Medica and Pharmaceutical chemistry.—First Class, L. C. Wooldridge.

The following Guy's men passed the Preliminary Scientific Examination at the University of London:—

First Division.—Messrs. E. L. Adeney, H. P. Berry, O. J. Currie, C. Gross, C. S. Harper, W. Lane, M. O'Kane, J. Smith, J. J. Udale.

Second Division.—J. H. Lister, J. Richmond.

RESIGNATIONS.

We understand that Mr. Stocker has tendered his resignation to the Treasurer and Governors, and that it has been accepted, so that in a few weeks he will leave us. Although we will all miss his well known form, no one will grudge him his well earned repose; and his name and his memory will long remain among us. The Rev. Philip Swatman, our Chaplain has also we believe announced his intention of retiring from the chaplaincy shortly, but no steps have as yet been taken to fill his place.

ON DUTY FOR SEPTEMBER.

Senior House-Surgeon:—Mr. J. T. Brett.
Junior House-Surgeon:—Mr. J. Mackern.
Senior House-Physicians:—Mr. C. F. Pickering, Mr. A. G. Lacy.
Junior House-Physician:—Mr. W. P. Reynolds,
Senior in Charity:—Mr. A. G. Barrs,
Junior in Charity:—Mr. H. W. Ewen.

RESIDENT DRESSERS.

Messrs. E. C. Beale.
„ T. S. Sheldon.
„ J. Poland.
„ R. Birdwood.
„ H. C. Manby.

THE SCHOOL BUILDING.

But little progress has been made towards the completion of the new Physiological laboratory and class-rooms, since the mention made of them in our last number, owing to the recent general strike among the masons throughout London, caused by their demanding a penny an hour more wages, and an hour a day less work, giving as their reason for their demand, the high price of provisions and the flourishing state of the building trade, as well as their inability to get to their work so early as formerly, owing to the discontinuing of the early workman's train on the Metropolitan and Suburban line. To this demand the masters refused acquiescence, maintaining that neither was trade sufficiently prosperous nor the want of early trains a sufficient excuse for their granting the men's request.

Thus, amongst others, the contractor for our buildings was thrown back in his work and would have lost his contract, had it not been that he gave way to his men, thereby putting himself twenty-five pounds out of pocket.

As the building now stands, completion cannot be far distant, as the flat leaden roofing has been finished, and the men are now at work at the staircases and external ornamentation.

The style is classical, Doric we believe, consisting of pillars and straight lines.

The entrance corresponds to the old entrance to the Museums; a passage leads to the lobby outside the Anatomical Theatre (the scene of so many scuffles and scrimmages before the opening of the doors for Dr. Pavy's Physiological lectures), which is to be now occupied it seems by the staircase to the second floor.

On each side of the entrance passage a door leads to the ground floor rooms, that on the left being the larger, and both to be devoted to class-room purposes. Upstairs are three rooms of unequal size, one large room lighted by side windows and skylight, facing the "park," which is intended as the Physiological laboratory, and the other two of fair size occupying the remaining half of the floor, also lighted by side windows as well as skylights.

The old Gynœcological and Obstetric Museum has been done away with, being now taken up by the new staircases, and we believe one of the smaller upstairs rooms is to be devoted to that purpose.

That the addition has been made not before it was wanted all know, and we feel sure that they will contribute greatly to the comfort of both lecturer and student.

If finished in time it is intended that they shall be thrown open on the evening of the conversazoine.

MARRIAGES.

LAMB—PHIPPS. August 9th, at the Church of St. Colombo, Collingtree, W. H. Lamb, M.B., Lond., of Kensington-park Gardens, son of the late Rev. R. M. Lamb; to Agnes Mary, daughter of P. Phipps Esq., M.P., of Collingtree Grange, Northamptonshire.

GREEN—LEITH. On the 18th inst, at S. George's Bloomsbury, Alfred Withers Green, M.R.C.S., Eng., L.R.C.P., Lond., son of William Abbot Green, late Principal Inspector of Hospitals, Bengal; to Clara Maria Leith, daughter of the late John Kenneth Leith, Adjutant, H.M's. 12th Foot. No Cards.

Microscope, Binocular, superior make, for disposal. Mechanical Stage, with best English Object Glasses and large Stand Condenser. Owner has no use for same. Price, £14. Address—A. F., 56, Beresford Street, Camberwell.

STATISTICAL REPORT OF LYING-IN CHARITY FOR JULY, 1877.

Number of women attended				219
Recovered	219			
Died	0			
	219			
Single Births				218
Dual				1
				219
Women attended in 1st confinement				34
„ „ 2nd „				32
„ „ 3rd „				25
„ „ 4th „				26
„ „ 5th „				23
„ „ 6th „				27
„ „ 7th „				13
„ „ 8th „				16
„ „ 9th „				7
„ „ 10th „				6
„ „ 11th „				4
„ „ 12th „				4
„ „ 14th „				2
				219
Children at full time.				
Males alive...	96			214
Males dead...	5			
Females alive	113			
Females dead	0			
Premature children.				
Males alive...	1			5
„ dead...	3			
Females alive	0			
„ dead	1			
Abortion...				1
Total number of children				220
Alive	211			220
Dead	9			
Presentations.				
Vertex		213		
Breech		3		
Foot		1		
Face		1		
Shoulder		1		
Vertex with Hand		1		
		220		
Operations.				
Forceps	4			
Turning	1			
Craniotomy	1			
	6			
Externs attended.				
Mr. J. G. Barns				49
Mr. W. T. Crew				65
Mr. H. O. Stewart				52
Mr. R. W. White				53
				219

THOMAS R. JUDSON, M.R.C.S.,
Junior in Charity.

Guy's Hospital.—The Medical Session

commences on MONDAY, October 1st.

MEDICAL OFFICERS.

Consulting Physicians—Sir W. Gull, Bart., M.D., D.C.L., F.R.S.; G. Owen Rees, M.D., F.R.S.

Physicians—S. O. Habershon, M.D.; S. Wilks, M.D., F.R.S.; F. W. Pavy, M.D., F.R.S.; W. Moxon, M.D.

Assistant-Physicians—C. Hilton Fagge, M.D.; P. H. Pye-Smith, M.D.; Frederick Taylor, M.D.; James F. Goodhart, M.D.

Consulting Surgeons—J. Hilton, Esq., F.R.S.; E. Cock, Esq.; J. Birkett, Esq.

Surgeons—J. Cooper Forster, Esq.; Thomas Bryant, Esq.; Arthur E. Durham, Esq.; H. G. Howse, M.S.

Assistant-Surgeons—N. Davies-Colley, M.C.; R. Clement Lucas, B.S.; C. H. Golding-Bird, M.B.; W. H. A. Jacobson, Esq.

Consultiug Obstetric Physician—Henry Oldham, M.D.

Obstetric Physician—J. Braxton Hicks, M.D., F.R.S.

Assistant Obstetric Physician—A. L. Galabin, M.D.

Ophthalmic Surgeon—C. Bader, Esq.

Assistant Ophthalmic Surgeon—C. Higgens, Esq.

Dental Surgeon—S. J. A. Salter, M.B., F.R.S.

Assistant Dental Surgeon—H. Moon, Esq.

Aural Surgeon—W. Laidlaw Purves, Esq.

Medical Registrar—F. A. Mahomed, M.D.

Surgical Registrar—Frederic Durham, Esq.

Apothecary—James Stocker, Esq.

The Hospital now contains 695 beds, and includes wards for Obstetric, Ophthalmic, and other special departments.

In connexion with the Lying-in Charity, about 2500 cases are annually attended by the students.

Number of patients relieved during the year, abont 91,000.

LECTURES, DEMONSTRATIONS, and PRACTICAL COURSES.

Medicine—Dr. Wilks and Dr. Pavy.

Clinical Medicine—Dr. Habershon, Dr. Wilks, Dr. Pavy, and Dr. Moxon.

Surgery—Mr. Bryant and Mr. Arthur E. Durham.

Clinical Surgery—Mr. Forster, Mr. Bryant, Mr. Durham, and Mr. Howse.

Practical Surgery—Mr. Clement Lucas.

Clinical Lectures on Midwifery and Diseases of Women—Dr. B. Hicks.

Morbid Anatomy—Dr. Hilton Fagge and Dr. Goodhart.

Cutaneous Diseases—Dr. Pye-Smith.

Anatomy (Descriptive and Surgical)—Mr. Howse and Mr. Davies-Colley.

Practical Anatomy—Mr. Jacobson, Mr. Carrington, and Mr. Symonds.

Physiology and General Anatomy—Dr. Pye-Smith.

Practical Physiology—Mr. Golding-Bird.

Chemistry—Dr. Debus and Dr. Stevenson.

Experimental Physics—Mr. A. W. Reinold.

Practical Pharmacy—Instruction is given in the Hospital Dispensary. Clinical Lectures in Medicine, Surgery, and Midwifery, weekly.

Special Classes are held in the Hospital for Students preparing for the Examinations of the University of London and of the College of Surgeons.

The Museum of Anatomy, Pathology, and Comparative Anatomy—Curator, Dr. Fagge—contains 11,000 specimens, 4500 drawings and diagrams, an unique collection of Anatomical Models, and a series of 600 Models of Skin Diseases.

APPOINTMENTS.—The House-Surgeons and House-Physicians, the Obstetric Residents, Clinical Assistants, and Dressers are selected from the Students according to merit and without payment. There are also a large number of Junior Appointments, every part of the Hospital practice being systematically employed for instruction.

ENTRANCE SCHOLARSHIPS.—Open Scholarship of One Hundred Guineas, in Classics, Mathematics, and Modern Languages. Open Scholarship of One Hundred Guineas, in Chemistry, Physics, Botany, and Zoology.

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FEES:—Frist year, £40; second year, £40; third year, £30; or £105 in one sum at entrance, or in two moieties at the commencement of the first Winter and of the following Summer Session.

Several of the Lecturers have vacancies for Resident Private Pupils.

For further information, apply to the Dean, Dr. F. Taylor, or the Medical Secretary, Mr. J. Stocker.

Guy's Hospital, July, 1877.

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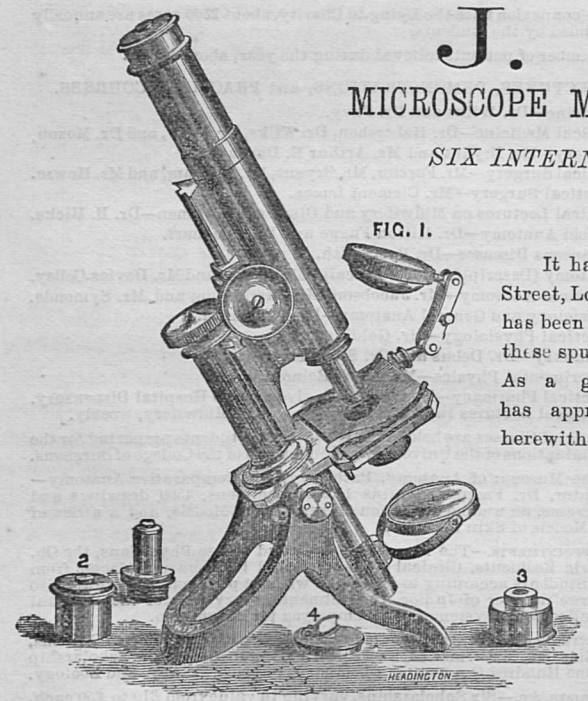

FIG. 1.

IMPORTANT NOTICE—JULY, 1877.

It having come to the knowledge of Mr. JAMES SWIFT, of University Street, London, that one of his registered Microscopes, similar to illustration, has been pirated, J. S. begs to caution all purchasers of Microscopes against these spurious imitations, which are of exceedingly inferior workmanship. As a greater precaution against this imposition, J. S. has appropriated a *Trade Mark*, a facsimile of which is herewith shown, which will be engraved upon every Instrument and important optical appliance which leaves his Establishment after this date. J. S. further begs to caution purchasers against buying second-hand Microscopes and Objectives bearing his name, as an unwarrantable liberty has been taken in affixing his name to such articles, and J. S. will have no objection to inspect, free of charge, any such Instruments or Objectives, to ascertain whether they are genuine.

ILLUSTRATED CATALOGUE FOR STAMP.

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Guy's Hospital Gazette.

A Students' Journal of Hospital News, Medicine and Surgery.

NEW SERIES.—No. 22. OCTOBER, 1877. SIXPENCE.

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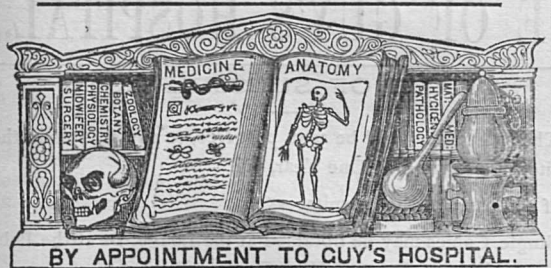

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Charing Cross ...	1 p.m.	1 p.m.	Tu. F. 1.30	...	M. W. F., 9
Guy's	1.30 p.m.	1.30 p.m.	M. W. F. 1.30.	M. Th. 1.30 Tu. F., 12.	Tu. Th. F. 12
King's College ...	2 p.m.	1.30 p.m.	M. W. F., 1 p.m.	M. Th., S. 1	Tu. F., 10
London	1.30 and 2 p.m.	1.30 and 2 p.m.	...	W. S., 9	Tu., 9
Middlesex	1.30 p.m.	1 p.m.	M. W., 1.30	Tu. F., 8.30	Daily, 9
St. Bartholomew's	1.30 p.m.	1.30 p.m.	M. Th., 2 W. S., 9.	Tu. Th. S., 1.30.	Fr., 9
St. George's... ...	1 p.m.	1 p.m.	Th., 2.	W. S., 2	Tu. S., 9.30 Th., 1.30
St. Mary's	1.15 p.m.	1.15 p.m.	Fu. F., 9.30	M. Th. 1.30	W. S., 9.30
St. Thomas's ...	8.45 a.m.	8 a.m.	W. F. 12.30	Daily, 2, ex. S.	Tu. F., 10
University College	1.15 and 2.30 p.m.	1.30 and 2 p.m.	Daily, 1.30 ex. W. & S.	M. W. F., 2	W., 10.30
Westminster ...	1.30 p.m.	1.30 p.m.	Tu. F., 3.	M. Th., 3	W. S., 9·15

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CASE OF DOUBLE POPLITEAL ANEURISM TREATED WITH DIGITAL PRESSURE.

Communicated by Mr. H. L. Manby.

The following case may be interesting to some of your readers as showing what can be done in hospitals by relays of obliging students, though not practical in private practice. I therefore take this opportunity to thank, on the part of the patient as well as on my own behalf, all those students who kindly helped in partially curing the above case.

F. S., æt. 38, labourer, was admitted into Naaman Ward, under Mr. Howse (whose work Mr. Jacobson was then doing), on August 18th, 1877.

Family and personal history good. A single, steady man; no history of rheumatism nor syphilis; temperate. Has always worked hard and walked a great deal Three or four months before admission he ran a "pick" into the outer side of his right foot (this, *he says*, was the cause of the aneurism). A month after this he walked 37 miles in three days, this was followed by a great deal of pain in his right knee, and he then noticed a swelling in the popliteal space, about the size of a hazel nut, which afterwards extended toward the inner aspect of the joint. He kept at work for two days, but noticed the swelling "throbbed." Was admitted into —— infirmary.

On admission.—Patient appears a healthy muscular man, but with a slight dusky tinged skin. The right leg, from the knee downwards to the dorsum of the foot, appears swollen and œdematous; he cannot completely flex or extend the limb. There is a swelling filling the right popliteal space, the limits of which are not easily definable, expanding equally in every direction. Pulsation is distinctly visible along Hunter's canal; on pressure over the femoral, pulsation ceases, but the tumour does *not* decidedly diminish in size; there is a decided bruit in the tumour, and at the heart the first sound appears roughened at the apex, though it cannot be called a decided bruit. A smaller pulsating tumour, the size of a pigeon's egg, occupies the left popliteal space.

On August 21st digital pressure was first applied, commencing at 9·45 a.m. A subcutaneous injection of morphia (gr. $\frac{1}{3}$) was given within the first ten minutes. Temperature, 99·6°; pulse, 88. The limb being placed on a pillow, semiflexed at hip and knee and rotated slightly outwards at the hip-joint, the femoral artery was compressed on the brim of the pelvis by relays of students, two being in constant attendance for an hour at a time. assisted by a compression weight. 2·45 p.m.—Becoming rather restless. Inj. Morph. gr. $\frac{1}{4}$. Still pulsation in Hunter's canal, evident on changing digits, though apparently much diminished and the tumour hardened. In the popliteal space the pulsation is more evident toward the outer side than internally. 6·30 p.m.—Pulsation, even on removal of all pressure, is scarcely felt; patient says he cannot now feel it throbbing; there is a small branch of artery, however, felt beating over the margin of the swelling. 10 p.m.—Patient sleepy. There is decided pulsation toward the outer side, though apparently more distant to the touch; the inner part is much firmer. During the last two hours has had cramps, easily relieved by slight changes of position. His groin is rather tender, but altogether he does not appear worse for the day's work. He was tied down in the same position and given $\frac{1}{2}$ gr. Morph. subcutaneously, pressure being stopped, having been applied twelve hours as near as possible.

During the twelve hours the patient took about a pint or a pint and a half of milk at intervals, some fish for dinner, an egg about 5 p.m., and half a pint of beef tea before he was made comfortable for the night.

August 22nd.—Had a good night. There is pulsation though greatly diminished. Temperature, 100·2°; pulse, 84. The femoral was again compressed at the same place, commencing at 1 p.m., *i.e.*, after fifteen hours intermission. He was more restless than yesterday, Inj. Morph. gr. $\frac{1}{3}$ at 1·30, and again at 7 p.m., after which he even slept while the weight was on. 8·30 p.m.—Pulse was noticed in the dorsalis pedis artery, though no pulsation was felt at the swelling. 9 p.m.—Pulsation felt on changing fingers. 11·15 p.m.—No pulsation on removal of all pressure. Leg again tied down, and Inj. Morph. gr. $\frac{1}{3}$. No bruit to be heard, but there is a small branch of artery felt beating over the hardened mass.

August 27th.—Moved off the bed for the first time.

August 30th.—Leg rather more extended.

September 3rd.—The tumour still feels elastic to touch. Up to the present he has been allowed *low* diet with fish, *no* stimulant whatever. Had ordinary diet to-day for the first time.

September 6th.—The tumour appeared much firmer, the limb can be extended almost to normal, there is no pulsation.

On September 12th an attempt was made to cure the left and smaller aneurism. One did not expect to be so successful with this, and our expectation was verified by the result, although other circumstances were exactly similar, many of the students who had helped us before helping us now; diet being the same and the same amount of morphia given subcutaneously. Pressure was kept up from 9·30 a.m. until 11 p.m., and on entire removal the pulsation appeared considerably diminished

September 14th.—Pressure was again applied at 9·30 a.m., after an interval of 34½ hours, and maintained until 9·30 in the evening, when pulsation was still evident, though probably less than at the first.

Remarks.

This appears an instructive case from the fact of the patient having one kind of aneurism on either side, and from the above proving the fact that sacculated

aneurisms are the best to be treated by digital pressure; but not so the fusiform. To the right side, which was probably sacculated, pressure applied for 22 hours proved successful; whereas the left, or fusiform, was unsuccessfully treated for 25 hours.

Mr. Bryant, in his work on surgery, states that compression should not be used when the leg is œdematous. I would, however, suggest that unless the œdema be *very* great an attempt be made, for in this case the side cured was œdematous and the venous system of the leg rather congested; this, probably, was increased by his walking on coming to the hospital, for it certainly diminished by the next morning, though three days after admission, when pressure was first applied, these symptoms were still marked.

It may be interesting to remark that on September 3rd, *i.e.*, the twelfth day after compression, the tumour was still felt to be elastic, the patient still being on *low* diet; but that on the 6th, *i.e.*, *three* days after the patient had received ordinary diet, it was noticed to be much hardened. Would it be saying too much to suppose that this might, in part, at least, be due to the more fibrinous repast.

That in such cases as the above it is well to use morphia pretty freely is undoubted; for though a very patient man on the whole, he became restless at times, but was soon quieted by "a third" or "a quarter."

I would also suggest that a little power-of-fear be used, as well as explaining your *modus operandi* to the patient; though it does seem hard to do so. I still maintain that it is perfectly justifiable to tell your patient he may eventually lose his leg if he do not lie still and allow you to do your best without the use of the knife, especially when you have to deal with a patient, such as the above, who would rather have anything done than feel "cold steel."

I was several times asked why an instrument could not be used instead of digital pressure.

That the elasticity of digital pressure is greatly overcome by the use of a weight applied over the fingers is undoubted. It appears that the greatest advantage is due to the non-compression of the vein in the latter treatment, though probably the weight bruises the tissues less. The amount of bruising, however, by digital pressure, with the frequency of changing, is not so much as might be expected, if at least ordinary care be taken, using plenty of dusting powder, &c., &c.

To sum up, one would say that large *sacculated* aneurisms may well be treated by digital or any other pressure; whereas the best treatment for *fusiform* aneurisms would be to ligature at once, after perhaps giving the collateral circulation a fair chance to increase by pressure applied proximally for about ten or twelve hours; if there be no decided improvement by that time it is certainly a waste of time and energy to keep 24 pairs of hands engaged for variable periods during the next twelve hours.

I hope this patient will submit to the ligaturing of his femoral, for I feel sure he will never walk tabou with double popliteal aneurism, both cured by digital pressure in Guy's Hospital, as I hear a gardener in Covent Garden is now doing.

CASE OF TETANUS.

J. B., aged 24, by occupation a labourer, was admitted into Cornelius Ward, on September 6th, with the following history:—

Family history.—Good.

Previous history.—Has always been strong and healthy. Never drank much, and for the last four years has been a total abstainer. No history of syphilis.

History of present attack dates from Tuesday week (August 28th), when he was working as a bricklayer, some quicklime made its way through a crack in the boot of his right foot, just over the metatarso-phalangeal joint of his great toe on its dorsal surface. This caused the foot to be sore, and in consequence he left off work earlier than usual on that day. He, however, was able to work till the *Saturday*, and felt no inconvenience at all till the *Friday*, when he first noticed pain and stiffness in back and neck, with slight "cramps" in his lower jaw. On Saturday he again went to work, and did his usual half day's work, but the stiffness in back and jaw became worse.

On Sunday he first noticed some starting in his limbs, and his friends noticed he had an "odd sort of smile."

On Monday he was much worse. A medical man was called in, who ordered a medicine in the day-time, with a sleeping-draught at night. The spasms were very strong and of long duration, following quickly one after the other, he sleeping in the intervals.

On Wednesday about the same during the day, but worse at night.

Throughout his bowels had been open, and he had taken plenty of fluid nourishment, though unable to swallow solids.

On Thursday, September 6th, he was admitted inty Cornelius Ward. The spasms were coming on vero quickly and strongly. There was marked opisthotonos, and the risus was distinct, though not excessive. Countenance pale and anxious. Mind clear Profuse sweating. Temperature, 99·8°; pulse, 108. There is a small scar over wound, which is entirely closed. The muscles of the forearm seem to be unaffected. There is great pain over the lower part of the thorax during spasms. 3 p.m.—Morphia injection gr. $\frac{1}{2}$. 3·30 p.m.—Ice-bags to spine. Nitrate of Amyl in 5 ♏ doses to inhale was twice repeated, but seemed to bring the spasms on all the stronger. Temperature, 100°. Milk $\frac{1}{2}$ pint. 5 p.m.—Morph. injection gr. $\frac{1}{2}$. Ice-bags renewed. Is very much easier. Spasms

hardly affecting jaw at all, though before his coming in the tongue was frequently bitten during the spasms. Has had a pint and a half of milk since 2·30 p.m. Temperature, 99·8°. 7·30 p.m.—Morph. gr. ½. Milk and egg, one pint. Inclined to sleep. 11 p.m.—More comfortable. Ice-bags renewed. Morph. gr. ½.

September 7th, 1·45 a.m.—Had some sleep. Milk one pint. 4·30 a.m.—Morph. ½ gr. 7·30 a.m.—Morph. ½ gr. 11 a.m.—Has had some intervals of sleep; seems more comfortable. Spasms very quick and strong at present. Great pain in ribs and abdomen. Takes milk well. Temperature, 99·4°; pulse, 100. 11·30 a.m.—Morph. gr. ½. 3 p.m.—Morph. gr. ½. Milk and beef-tea. 7·30 p.m.—Morph. gr. ⅓. Ice renewed. Spasms worse. Urine drawn off. 10 p.m.—Ext. Physostigmæ Fabæ gr. ⅛. 12 midnight.—Repeat.

September 8th, 3 a.m.—Repeat. 8·30 a.m.—Morph. gr. ½. Urine drawn off. Spasms during night worse and worse, stronger, and follow on one another more quickly. 11 a.m.—Better since last injection. Temperature, 99°. 12·15 p.m.—Urine drawn off. Repeat inject. and Calabar Bean. 3 p.m.—Easier. Temperature, 98·8°. Is to have ⅛ gr. of Ext. Physost. at 4, 5, 6, and 7 p.m.; also inj. of Morphia, if required. 6 p.m.—Urine drawn off. 9·45 p.m.—Ditto. Calabar Bean gr. ¼. 11·30 p.m.—Bean g.. ¼.

September 9th, 12·30 a.m.—Urine drawn off. In great pain. Spasms strong and frequent. 10 a.m.—Has passed a very bad night. Had the four doses of bean in four hours, but with apparently no effect in relieving the spasms. Temperature, 99·4°; pulse, 104. 4·30 p.m.—Morph. gr. ½. 7·30 p.m.—Morph. gr. ½. Urine drawn off. Much relieved by the last two injections. 12 midnight.—Morph. gr. ½. Water drawn off.

September 10th, 3 a.m.—Morph. gr. ½. Urine drawn off. 7 a.m.—Repeat. Very bad night. Spasms succeeding each other more quickly and seem stronger than ever. Bowels not open. He takes his food, milk, beef-tea, and eggs, well. Complains more of "aching than stiffness." Can now move his legs somewhat, which he has been unable to do since he has been in. Temperature, 99·4°; pulse, 116. 2·45 p.m.—Urine drawn off. Morph. gr. ⅓. 3·45 p.m.—Had some sleep. Easier; spasms not so severe. Temperature, 101°; pulse, 96. Morph. gr. ½. 8 p.m.—Morph. gr. ½. Urine drawn off.

September 11th, 12·30 a.m.—Morph. gr. ½. Urine drawn off. Easier. 4 a.m.—Repeat. 10·30 a.m.—Passed a better night, having had a good many snatches of sleep. The spasms are less frequent and not so strong. The muscles of the legs are markedly less affected. Takes his fluid nourishment well. Temperature, 101·8°; pulse, 100. 2·40 p.m.—Morph. gr. ½. Urine drawn off. 4 p.m.—Temperature, 100·6°; pulse, 116. Is much easier since last injection. Can move his neck from side to side for the first time. Had a short spasm of muscles of jaw, which, however, passed off very quickly. Is much more cheerful. 8 p.m.—Morph. gr. ½. Urine drawn off.

September 12th, 12·30 a.m.—Morph. gr. ½. Urine drawn off. 7 a.m.—Repeat. 9·45 a.m.—Temperature, 100°; pulse, 112. Fair night, though not much sleep. Complains of great pain through chest to back during spasms. Can move his legs and neck better. Seems cheerful. Takes his food well. Urine still has to be repeatedly drawn off. 3 p.m.—Morph. gr. ½. Temperature, 101·2°; pulse, 110. 7 p.m.—Repeat.

September 13th, 12·30 a.m.—Morph. gr. ½. 7 a.m.—Repeat. 10 a.m.—Repeat. Temperature, 103°; pulse, 110. Better; spasms less frequent. Diaphragmatic pain less. 1·30 p.m.—Temperature, 103·2. Morph. gr. ½.

September 14th, 2 a.m.—Morph. gr. ½. 10 a.m.—Repeat. Passed water off himself. 7 p.m.—Repeat. 10 p.m.—Chloral Hydrate gr. xx.

September 15th.—Passed very fair night. Now passes urine of his own accord. Eat fish yesterday. Temperature, 101·4°; pulse, 106. Morph. gr. ½.

September 16th.—Chloral repeated last night. Was very restless and irritable all night; better this morning. Bowels opened well with Ol. Ricini. Temperature, 101°; pulse, 80. 9·30 p.m.—Morph. gr. ½.

September 17th.—Chloral omitted. He moves his neck more freely, and complains only of pain in back. He takes his food well. Passes his water naturally. Temperature, 100·6°; pulse, 100. 12·30 p.m.—Morph. gr. ½. 4 p.m.—Temperature, 101·4°; pulse, 98. 11·30 p.m.—Morph. gr. ½.

September 18th.—Holds his ground well. A fair night with a good many snatches of sleep. The spasms are decreasing in frequency and intensity. 10 a.m.—Temperature, 101·8°; pulse, 110. Morph. gr. ½. Ol. Ricini oz. ½. 4 p.m.—Temperature, 101·4°; pulse, 104. Slept good deal since morning. 11 p.m.—Morph. gr. ½.

September 19th—Passed very restless night; this morning seems no worse. The spasms are very much less frequent, and now seem to come on only when he is suddenly disturbed. Sleeps well in day-time. Countenance for last few days has been of a peculiar bluish hue. Temperature, 102·4°; pulse, 98. Morph. gr. ½, night and morning only.

(To be continued.)

We give the above interesting case of tetanus taken *in extenso* from the report made by Mr. J. A. Scott (to whom our thanks are due for it), thinking that it deserves a full description, both on account of its long duration, and what we hope may prove its successful termination.

It will be seen that repeated and fairly large subcutaneous injections of morphia have been the principal treatment. Nitrate of amyl was tried, but we must confess had scarcely a fair trial. Not so calabar bean—so much lauded of late at St. George's—which in this case thoroughly and progressively tried has certainly failed.

An anonymous writer in the *Practitioner* for August gives an interesting retrospect of the medical treatment of tetanus, from which we extract the following notes:—*Chloroform* has had an extensive trial; it has been administered in large

quantities, sometimes with apparent success. Simpson narcotised a child for thirteen consecutive days, using ℥ 100 with mercury. *But the general result is that while all the fatal* symptoms disappear on the inhalation of chloroform, they return on its removal with unabated violence, and the disease generally lands them to its fatal conclusion without delay. *Chloral hydrate* has now taken the place of chloroform in the treatment of tetanus, but without more success. There appears to be great tolerance of the drug, and a case is quoted of a child of 12½ years who took more than 100 gr. a day. Dr. Ballantyne, of Dalkeith, gave ℥ iij. in twenty-four hours, and ℥ vj. in five weeks, with success, the patient during this time being easily aroused to speak. It seems, however, to be a valuable drug in alleviating the symptoms. Its injection into the veins and its subcutaneous injection have not been so successful. *Calabar bean*, which, like chloral, affects the spinal cord, and has little or no action on the motor and senory nerves, has been recently much employed. As with other drugs, its administration has been at one time apparently successful, and at another a perfect failure. It has, moreover, to be given in comparatively large doses. The spasms are controlled and the body heat sinks, and if the drug be withheld the paroxysms return, while if it be pressed the patient comes into a somewhat dangerous condition. A large dose is required to produce by subcutaneous injection contraction of the pupil, sometimes as much as ⅓ gr. every two hours. There is not much to be said in favour of either *opium* alone, or opium combined with chloral; while *nitrate of amyl, bromide of potassium*, and *conium* have been alike tried in vain. A more favourable report is given of *aconite*, the exhibition of which has been attended in some cases with remarkable results. It lowered the pulse, which fell in one case from 135 to 60, with a simultaneous decrease of the convulsions; but the effects of the drug constitute in themselves a new danger which must be carefully controlled. Tendency to syncope, wakefulness, vertigo, dilatation, and insensibility of the pupil; small, intermittent, and irregular pulse, and increased irritability of the nervous system are often the result of giving this remedy. The writer of the article referred to believes that such a summary as he has given makes an appeal to pathology to throw fresh light upon this disease, and he hopes that some combination of these agents will be able to accomplish what each one of them singly has been found unable to accomplish.

We have no doubt that we shall one day find a remedy that is as really successful in the treatment of tetanus as the bromide of potassium has been found to be in some forms of epilepsy; but just as we are not indebted to pathology for the discovery of the therapeutic virtues of the bromide in epilepsy, so we are far from being sanguine that pathology will point out by-and-by the drug or combination of drugs which will cure the disease under consideration. In all probability the chemist or botanist has already provided the remedy; and perhaps it remains for empirical experiment, rather than for physiology or pathology, to find it out.

The following, evidently written by a candidate for Prelim. Sci. Lond. Univ., we found; whether intended for publication by us, or any other journal, we know not; still we give it.

A DAY-DREAM—A REALITY.

To-morrow! To-morrow! To decide, in part at least, whether I am to remain the humble being I was created; or, following the first devices of that once mass of embyronic cells, yet now the chief power of my frame, to become a greater man—a mind of mightier stamp.

Shall I wander and fancy that I may, in some day, attain that high distinction of making others created after my own form envious; aye! even tremulous? Nay! this is no time for jesting: by the light of lamp or gas let me think and smoke. Have I not passed the last six hours—day of rest *though it be—beneath the trees in the neighbourhood of the* bustling park, whither I repaired for fresh air, in sober thought, jotting down each item that noble Sensorium cannot follow to its end, to "look up" on my return, before the hours of bliss remove my thought? Yet read! it were impossible at such a time; my head throbbing, every particle of every subject plainly seen, in part at least, before my eyes; still not perfect, for before a mechanical philosophy problem is solved—my eyes following each figure in space—a question arises as to the order, sub-order, class, family, &c., of a flower on the table; uncertain which it be, before a Bentley is found on the now dismantled book-shelf, a spider crossing, what the pecularities of Insectivora? Surely not; it must be Arachnida. How muddled these stupid cells must be. Nicholson solves the question, evidently I speak before I think; this being the case, should I not indulge in a full dose of tartar emetic, leaving a public notice to all intending candidates to beware of such a substance in the practical examination?

What are the tests? I feel I know not, and yet I must, for I have analysed it. Well! another cigar may aid me. What; smoke again? Already every portion of every subject passes before my eyes in as many seconds. Yet sleep I cannot; read I dare not, lest the ganglionic cells become more entangled than before. It cannot hurt me, there is yet *ten* hours before the awful hour, and tradition says "*eight* is enough for a *fool*." So no sleep yet.

I read, "The order Leguminosæ is divided into sub-orders, i., Papillionaceæ; ii., Crustaceæ; iii., Arachnida." Certainly foolish! Yet after butterflies must come spiders; evidently there is something wrong. Let me try the parallelogram of Forces $A^2 = B^2 + C^2$, then $B^2 = A^2 - C^2$. At length I have found myself doing one thing correctly; take, therefore, five minutes rest on the sofa and puff away. Some three hours later—a triumph! What bliss!!! Honours in every subject. Alas! 'twas but a dream. Hasten to bed, but too late, repose has left me; I hear four, five, strike in the distance. Take a walk round the room, wider awake than ever. At 5·30 I have another smoke, and yet no sleep; at last "Ben" drolls out six. I hear no more until a sudden thud at the door—"Please, Sir; I've called you three times, and it is now a quarter past nine." I miss my bath, scarce do I dress respectably; breakfast almost *nil*. Drive as fast as possible to Burlington Gardens; "block in the street, Sir." "Quick, then; try another." Good, very good. I arrive at ten minutes before ten, but in such an uncomfortable state; however, after finishing my toilet, I reach the examination-room, *very* nervous, at five minutes past ten, hardly daring to look at the questions. I place my *name* at the top of the paper in automatom style; this I do not find out until I have written one question at 10·30. I finish all the answers, yet know *I must* have done badly. I reach home at 7·30, and judge from what my "friends in adversity" tell me, I've done vilely. Dinner being out of the question, as I must look out the right answers, and some "tips" for to-morrow, and then retire.

* * * * * * * *

At length in the early morn I find myself tired and almost worn out,—for my eyelids have not closed the night—hardly able to pace that awful portico, deep in thought, yet smoking, for therein resteth my sole consolation at such a period. I the only one so eager to know the result; were not candidates numbered by tens? Then why this solitude? After another hour of suspense those stately portals open. I find "The List" was published last night, and yet I knew it not. I make a fearful rush toward the names, but am accosted thus,—"Leave your cigar outside, please, Sir; no smoking here," reminding one of the fearful apparition, "Thou art too late, thou cans't not enter now." Scarce does that dangerous element, so wisely termed a cigar, reach the middle of the road, when, alas! I perceive it was my favourite briar. My

thoughts absorbed, I had heard mention of a cigar, my smoking, and throwing it away; the act was automatic.

I return, steadily gazing at the list, being especially careful to commence at the bottom: I reach the top name of the second division, spun! 'tis too true. I retrace my steps in silence, but have taken but a few, when a hand is thrust into mine, followed by a volley of congratulations; I find it is my late professor, who has found my name in the *first division*.

PHYSICAL SOCIETY.

The following papers are announced for the Session 1877-78:—

October 6th.—"Some points in the Pathology of the Blood." Mr. George Mackern.
„ 20th.—"Intrathoracic Aneurism" Mr. D. Hartley.
November 3rd.—"Secondary Hæmorrhage and Torsion of Arteries." Mr. John Poland.
„ 17th.—
December 1st.—"History of the Food in its course through the body." Mr. W. H. White.
„ 15th.—"Physiological Therapeutics." Mr. A. E. Maylard.
January 12th.—"Intestinal Obstruction." M. G. H. Russell.
„ 26th.—"Calculus Vesicæ: its varieties and treatment." Mr. F. H. Berry.
February 9th.—"Antiseptic Surgery." Mr. G. F. Pilkington.
„ 23rd.—"Physiology of Central Nervous System." Mr. L. C. Woolridge.
March 9th.—"Pyæmia." Mr. H. L. Manby.
„ 23rd.—"Interstitial Nephritis." Mr. T. S. Sheldon.

The above is perhaps as varied a list as our old though vigorous society has ever published, the departments of physiology, therapeutics, pathology, medicine, and surgery are all represented; so that none can complain this Session of the intellectual feast being too high or too low. We especially call the attention of second and third years' men to the physiological papers, which may prove of valuable use to them, the discussion they are sure to raise may serve to clear up obscure or illdefined ideas gained from reading but one book, even on the eve of an examination two such nights cannot but be profitably spent.

One great cause of regret however exists, and it is that two presidents are obliged to step in and fill the first two nights in October, and besides this there is another awkward gap in the second evening in November. It seems strange that in such an institution as this such difficulty should be experienced in getting men to read papers; with the immense amount of material we have here to work upon, and with the large number of students, it appears unaccountable that *twelve* men cannot be found to volunteer; this year the presidents report they have had great difficulty in persuading men. We boast of our Physical Society as being one of the oldest in London, and we also boast of its flourishing condition, and it is, therefore, most humiliating when we hear of three vacant evenings out of a total of twelve, and that no essay was sent in last Session. We do not feel inclined to confess that we have not as many good men as we had in former years, nor, indeed, would it be true; there are plenty of men able to do papers most creditably and with immense advantage to themselves, but it seems impossible to overcome the condition of *inertia*. In many things we have no idea what we can do till we try. There is still one evening vacant, and we hope that a candidate will be forthcoming speedily. Meanwhile, we most cordially wish success to the new Session of the Physical Society.

We have been requested to remind present members of the Physical that the subscription extends over *three years*, after which no member pays another subscription, and that members of one, two, and three years standing will much oblige by coming forward with their subscriptions to one of the presidents, who have plenty to do in collecting fresh ones.

Correspondence.

WOMEN MEDICAL MEN AND THE LONDON UNIVERSITY.

To the Editor.

Dear Sir,

This appears a seasonable time—the commencement of the Winter Session—to direct the attention of members of the above university to the fact of the Senate lately over-ruling Convocation on the above subject. That one part of the governing body should over-rule the other is certainly lamentable in the extreme. "A house divided against itself, falleth;" therefore, if this be the case, we cannot expect a university such as the above to prosper.

My only hope is that members of the Senate, knowing the importance of such a subject, and the seriousness of contending with members of Convocation, have well weighed the matter in every view, and not given their vote *casually*. I will not say they have allowed popular clamour to carry them in their decision, which means, that they have voted for women merely because some of their best patients wish their daughters to depart from their proper vocation.

It appears to me that such an important subject as the above should be discussed, not merely by members of the Senate and Convocation, but also by other members of the University, undergraduates though many of them be.

To argue that one is jealous of the fair sex is simply preposterous. What would housewives say, I wonder, if we took to managing household matters, except to aid them by a second opinion? No! a place for everyone, and everyone in his (or her) place. Our dissecting-room, though a model in itself, is certainly not the place for *a lady*.

I fear, Sir, I am trespassing to too great a length on your valuable space, my object in writing this letter not being to discuss our relative positions, but to inform *undergraduates*, both of Guy's and any other hospital, that I shall be happy to see any and talk over with them the desirability of petitioning the Senate on the above subject.

I am, Sir,
Yours faithfully,
HERBERT L. MANBY.

Guy's Hospital, S.E.,
Sept. 17th, 1877.

GUY'S HOSPITAL GAZETTE, *OCTOBER*, 1877.

ONCE more the 1st of October has brought with it many new faces, and once more is it our duty and pleasure to welcome those who have chosen Guy's Hospital as their *alma mater*. A goodly number, this year, have set their shoulders to the wheel, and we congratulate them on their choice of a profession, and we can confidently say they will not find this wheel as capricious and uncertain as the classic and farfamed wheel of fortune. Rarely is it that honest hard work is not well repaid, and medicine is not one of the exceptions.

Most of the men have probably already tasted work in the shape of preliminary examinations, and some may imagine that their future medical examinations partake of their character, and are to be prepared for in the same manner. In a good many respects this may be true, and *all* examinations require systematic work; the accumulation of many facts, followed by a process of sorting and arranging; the classes and subclasses so arranged, to be made up into orders; these orders to elucidate and illustrate principles; and, finally, the development of these latter into laws. In the study of an exact science, as Mathematics, all this can be done; some think that Botany can also be added to the list. But in the study of Medical science the seeker after laws is doomed to disappointment at present; for, even in the most perfected part, namely, human anatomy, the exceptions and abnormalities are too many. Of course, medical study includes the study of an immense number of facts, thanks to the vast number of good observers, many now even hard at work, but the hitherto Student of Arts can console himself by discovering that he is to learn nothing disconnectedly at a hospital, not even during his first two years; we do not know so much about anatomy and physiology that we can afford to dispense with some of what we learnt of them in our pathological studies in later years. No; the sooner the tyro in medicine gets rid of the idea that anatomy and physiology are to be learnt for the purpose of passing an examination at the end of his second winter, the better; of course that important ordeal must be passed, and every first-year's man rightly starts with the intention of "doing it in April year." But the feverish condition of the three months preceding the examination is often known by its effects, but a short time afterwards perhaps, in the *real* application of anatomy and physiology at the bedside. This is, however, a well-known evil, and it would be a mistake to bring it up continually before junior men *ad nauseam*. After all, a man must think out, and find out the reasons of, these things for himself: a repetition of it here seems not altogether out of place. The educational resources of Guy's this year are not lessened, but rather increased; it remains to be seen how far the men determine that a good result be obtained. We are all proud of our noble hospital, we all want to do it justice, a good start is very favourable to that end. A strong *esprit-de-corps* is said to characterise Guy's men, no one then would like to be left behind his year. Friendships formed over the first subject in the dissecting-room are often fostered by three hours of mutual silent agony at the First College, are strengthened most of all by companionship in appointments in the wards, and are sure to bear happy fruit in the after history. A student at Guy's, or any other large hospital, is plunged into quite a little world; necessarily, therefore, a level is found there, and necessarily also effects are seen afterwards.

Introductory Addresses are rapidly going out of fashion; very often certainly they only gave the orator an opportunity of airing his own peculiar views on medical ethics, and on things in general; but a modicum of solid good advice was usually mixed up, which, carrying the weight of authority with it, was probably productive of much good. Another reason, too, why this advice stood a fair chance of being appreciated was that it was given to men early in their career, just at the time, in fact, when it was wanted. This Session, following the precedent established last year, there is to be no Introductory Address, consequently there will be no opportunity of covering oneself with glory by scaling the pillars in the anatomical theatre, and hatters will not reap the usual harvest. Last year science heralded in the new session, and a most enjoy-

able evening was spent with the aid of microscopes and electricity. We trust, then, that our freshmen will believe in the advice, although they may not hear it, and that the little peep at science they may obtain shall encourage them to search deeper into her stores of treasure. Not that pathology is to be learnt altogether by the microscope and chemistry, but, there can be no doubt of this, that Medicine, taking the word in its broadest sense, is becoming a position more and more every day to profit by the application of its collateral sciences. Many men probably will be startled, on taking up a Hermann's Physiology, to see how much mathematics is necessary to understand the chapters on the eye and on muscle, but a little experience will soon show them the necessity of specialism for the few, if not for the community.

Very briefly, then, we have tried to point out the many advantages, and the large margin, that the medical student has in his studies, and we look forward to the termination of the *Annus Medicus* 1877-78 as showing that good work has been done in a profession where so much can be done, has been done, and is yet to be done.

PYREXIA AND METHODS OF REDUCING IT.

Second Prize Paper (equal) read before the Physical Society, 1876-77.

By CHARLES KNOX SHAW.

(Continued from page 106.)

Before referring to the artificial means of reducing the temperature, it may be interesting to note the methods nature adopts to get rid of the superfluous heat.

A certain amount of heat is discharged by sweating from the skin. Dr. Leyden investigated this subject by means of a water calometer and came to the conclusion that in fever the loss of heat was double that of a normal state of health.

Dr. Leyden and Dr. Riegel have also proved by experiment that there is a discharge of heat by respiration, but this is so slight that it scarcely affects the temperature at all.

By fever also causing a quickening of the action of the heart, more blood is sent from the hot interior of the body to the surface of the skin to be cooled. There is an interesting experiment shewing that increased blood supply to the skin causes a lowering of bodily temperature.

I quote from Carpenter's Physiology.

"A curious experiment made by Bernard tends to show that the quantity of blood taken up by any one organ, is supplied to it at the expense of another, and that the excess of heat developed is compensated by a diminution in some other part. He found that on making a section of the sympathetic in the neck of a rabbit, both of whose ears had previously a temperature of 95° F., the temperature rose to 100° F., on the side on which the section was made, whilst it fell to 91° F., on the opposite side." Others have also shown that the temperature was lowered in the rectum.

This I think ought to suggest to us the use of drugs that will paralyse the vasomotor nerves, and cause consequently dilatation of the capillaries, and act upon the heart and cause increased flow of blood to the surface.

In febrile conditions, if there is hæmorrhage from the lungs, stomach, or intestines, it is generally followed by a lowering of the temperature, but when reaction sets in there is a compensatory rise.

On going round the wards a little time ago, I understood Mr. Howse to say that secondary hæmorrhage was followed by a sudden rise in temperature.

Vomiting and diarrhœa for a time reduces the temperature but there is generally a subsequent rise, which in some cases may exceed the previous temperature.

I have now come to the second part of my paper which I hope to make as practical as possible, by not going into any description of the drugs mentioned but by giving the best way of using them, and only just alluding to the general opinion as to their method of action.

There are two ways of reducing the temperature, the first which I shall describe is reduction directly by cooling the surface of the body; and the second is reduction by means of antipyretic drugs.

Of course one cannot go into the action of all the antipyretic drugs, but we may talk over the most important. I shall commence by describing the method of reducing the temperature by the external application of cold water.

The practice of reducing temperature by means of cold baths has come so much into vogue of late that it may be interesting to glance at its history.

James Currie in the latter part of the last century first made use of the cold water treatment in febrile affections.

In 1861, E. Brand, of Stitten, published a book on the hydrotherapy of Typhoid fever, which caused the whole subject to be impartially and scientifically investigated.

Jurgensen soon after published a work in which he stated that if energetic withdrawal of heat from the body was to be followed by any marked results, it must be repeated as often as the temperature of the body was above a certain point; and also that patients endured the repeated withdrawal of heat without experiencing any bad effects.

Menieyer was one of the first on reading these articles to attempt the cold water thoroughly.

He used to wrap his patients in cold wet sheets, the proceeding being repeated at the end of ten to twenty minutes, until the desired reduction of temperature was obtained.

But later on he used the baths in the manner to be presently described.

Liebermeister has had more experience of the cold water treatment of fever and more particularly of typhoid fever, than perhaps any other man; and it is he who is the great advocate just now of this special form of treatment.

He recommends a full length cold bath of 68° F., the same being used for several successive baths for the same patient. The bath should last about ten minutes, the patient should be then taken out wrapped in a dry sheet and put in a warm bed, covered up lightly and given a glass of wine.

Feeble patients are more easily influenced by the bath and should therefore be only kept in five or seven minutes.

Some authorities assert that this rapid method of reducing the temperature causes at the same time an increased production of heat, and accordingly Zienessen and others reduce the temperature by placing the patients in a bath of 96° F., and gradually cooling it down to 72° or below, at the same time gently rubbing the body and limbs.

The patients will have to remain in the bath 20 or 30 minutes and then placed as before in a warm bed.

This method is much to be recommended in the case of feeble patients as there is less shock and less exhaustion caused.

During the course of a fever the temperature should be frequently taken, and whenever it rises about 103° the patient should be bathed; some, as Liebermeister, give the bath, whenever the temperature rises above 102°, and others, with Zienessen, require the temperature to be higher and do not bath until it reaches 104°.

But whatever standard you take for the baths to be effectual they must be persevered with, even though at first they produce less effect than was expected.

In obstinate cases the interior of the body is but very little cooled down by a single bath, and that but for a short time, and in about two hours the original temperature is nearly reached but in some cases the after effect lasts several hours.

So to do good the baths must be repeated every time the temperature reaches the standard at which it is decided to bath, until the fever abates.

The baths should be given during the night as well as the day, and they are also found to be more efficacious if given when the temperature has a tendency to sink spontaneously. that is from seven in the evening till morning, and again in the day from eleven till two o'clock.

If antipyretic drugs be used in combination with the baths, they are not required to be given so often which is a decided advantage. For it is only fair to add that in spite of the great good they do, they are extremely troublesome to give and require a great deal of care. At first also the majority of patients strongly object to them, but as a rule after a few baths they experience such a relief that in some cases they have been known to beg for them.

We have not used the baths very much in this Hospital, but Dr. Taylor speaking from the results of several cases of Typhoid fever and cases of Acute Rheumatism in which there was a sudden rise of temperature, in which the cold baths were used said "I feel sure that the bath has been in most cases markedly beneficial. The pulse has become stronger, the tongue moister and cleaner, and the patient has been roused from a drowsy apathetic delirious condition to one of comparative liveliness and decided comfort."

It is undecided whether the baths reduce the temperature by abstracting heat or by preventing its unnatural formation. Now since cold is known to have considerable power in arresting growth and development, it seems propable that external application of cold may act by causing an arrest for the time of the fermentative process going on in the body during fever and so cause a lowering of the temperature.

But Dr. Binz gives the following reason "In fever the vessels of the skin are generally much contracted. The cool water acts as a stimulant on them and causes a somewhat stronger contraction to take place, but this is only of short duration. Relaxation for a larger term is the necessary consequence. The hitherto bloodless and dry skin becomes filled and moist, and thus the indications of warmth goes on."

Only a high degree of weakness of the heart, loss of blood, or perforation of the bowels are contra-indications of cool baths. Menstruation and pregnancy, pneumonia and bronchitis if the fever is very high are not, and the baths may be given without fear of evil consequences.

Cold effusions are not so beneficial as the baths, but are much more pleasant to the patient, the same may be said of cold sponging, although this has even a less cooling effect than the effusions.

Cold packs are usually well borne, but it takes four consecutive packs to produce the effect of one bath.

Riegel speaks well of local applications of ice bags on the chest and abdomen in mild cases of fever.

Long continued application of cold to the heart or head, will cause a local lowering of temperature and so in a measure protect those organs from the effect of the fever.

Feverish patients are always exceedingly thirsty, and it is well to know that cold drink and swallowing ice cause a distinct fall in temperature, but unlike external applications of cold produce no compensatory increase in the production of heat.

Cold water enemata and the passage of ice into the rectum, ought to have a similar effect, but I am not sure they have ever been tried.

Quinine is one of the most powerful antipyretics known and consequently I place it first amongst these drugs.

It is now generally known that Quinine owes its action to its influence on the blood, and not on the nerves as was formerly supposed. Though Garrod still teaches that it arrests the progress of ague by a peculiar influence upon the nervous system. Even small quantities of it will destroy septicgerms, and arrest putrefaction, and if it be added to matter containing Bachteria and infusoria it will kill them.

Quinine then checks the activity of cells and so causes a decrease in the oxidation, and disintegration of the elements of the body, and this statement seems to be borne out by the fact that less urea is eliminated in the urine after its use.

Ague arises from the septic change set up in the blood by the introduction into it of a low vegetable organism developed from putrifying vegetable substances.

It has been proved by experiment that if Quinine is brought in contact, without the system, with the exciting cause of ague, it will check the further chemical development of that matter. And so it is reasoned that it does good in ague by checking the processes set up in the body by this organism.

Of course there are other theories as to its action but this seems the most reasonable.

Dr. Hall has suggested the use of Quinine administered hypodermically, in cases of sunstroke. He thinks the quinine acts here as a stimulant to the vasomotor and inhibitory nerves. As the essential cause of sunstroke is over heating of the blood and tissues and therefore decomposition of the nutritive material, it is probable that here also Quinine acts as a distant anti-zymotic, as it does in malarial fever.

The experiments to show the effect of Quinine on the pulse and temperature in *health*, are very unsatisfactory, but it seems that it has no permanent influence on the bodily temperature.

When Quinine is taken it passes readily into the blood and exists there unchanged not undergoing decomposition, remaining in the circulation several hours.

The general opinion seems to be that to have any effect as an antipyretic it must be given in large doses, from 8 to 48 grains. The largest dose given once a day being the most efficacious.

Liebermeister says "this dose must positively be taken within the space of half-an-hour or at the most an honr."

It may be given dissolved in some acid, or it may be given in the form of 7½ grains per dose every ten minutes, until the desired amount is taken.

The dose should be repeated in 24 hours, or what is perhaps better in two days.

Given this way its toxic symptoms are rarely reached.

The fall of temperature usually begins a few hours after taking the medicine, and is reached from 6 to 12 hours after, it then gradually rises again.

It should be used like the baths during the time when the fever tends to decrease.

The use of Quinine obviates the necessity of so frequently using the baths.

If it causes much sickness as it sometimes does, it can be injected into the rectum with a little Tincture of Opium.

Closely allied in their action to Quinine are Salicylic Acid and Salicin, the two latest febrifuges.

Their action is so nearly similar that in describing one I shall be describing the other.

Salicylic Acid is an antiseptic and anti-zymotic, and accordingly has the power of checking the activity of ferments, and the development of bacteria.

In all probability it remains a long time in the blood unchanged. Dr. Binz denies that it is changed into the Salicylate of Soda by the alkaline constituents of the blood, or if

it is so it is then the Carbonic Acid in the blood sets free the Salicylic Acid contained in the Salicylate of Soda.

There are two main theories as to its action, the first and most probable is that it acts antiseptically on the blood, the second that it prevents the oxidation of the tissues.

If required to reduce a sudden accession of high temperature it must be given in large doses from 10 to 60 grains at once, if this has no effect it may be repeated in about five hours, by which time if it has taken effect the maximum amount of fall will have taken place.

In a febrile attack it may be given in doses of 20 grains every one or two hours.

The Salicylic Acid can be given dissolved in Liquer Ammoniæ Acetatis. Salicin dissolved in hot water, the water being afterwards allowed to cool.

The pulse and respiration are said not to be affected by it.

When taken in large doses it may produce symptoms resembling Cinchonism.

Dr. MacLagan who has used these drugs very extensively in Acute Rheumatism, gives his evidence in favour of Salicin, as it is more pleasant to take and does not cause much disturbance of the digestive system, sickness and burning of the throat as Salicylic Acid.

It is most essential that these drugs should be pure.

Aconite is a drug fast rising into importance, but its value as an antipyretic drug is not yet fully known.

Dr. Fothergill says that Aconite slows and weakens the heart, causing less rapid circulation and consequently less oxidation, and so diminishes heat. He also explains the influence of Aconite on temperature by the fact of its dilating the arterioles and so causing more blood to be sent to the skin which is cooled by evaporation and exposure.

There is a disease of not unfrequent occurrence amongst students who are much in the wards, I mean Tonsillitis. In its acute form there is often a high temperature, sometimes as much as 104° F., with a full and rapid pulse and all the usual concomitants of fever.

It is to this class of cases, uncomplicated inflammatory diseases, that we apply the present remedy. From personal experience I can speak of its efficacy. After taking the drug the temperature goes down, the pulse is less rapid, a profuse perspiration breaks out, and one altogether feels much more comfortable.

It should be taken as recommended by Dr. Ringer, who says, "it should be given at the very commencement of the disease, the medicine should never be delayed, every hour is of importance. Half a drop or a drop of the tincture, in a teaspoonful of water should be given every ten minutes or a quarter of an hour for two hours, and afterwards hourly. If there is much prostration with feeble and weak heart a still smaller dose."

I have seen Aconite used in our wards, and as a rule the results were far from good, it being found that there was no fall of temperature. But the cases in which I have seen it used are not those in which it is likely to do good. It is not likely to do good in general tuberculosis, advanced phthisis, and such like cases, and it is in these that I have seen Aconite used as a last resource and because it has failed it has been put aside as a useless drug.

With this drug we may class the two next veratria and digitalis: both probably acting in a similar manner.

Veratria has not been much used in England, but it is strongly advocated as an antipyretic in Germany and America.

It acts directly on the heart, heightening the pressure of of the arterial system. It sometimes causes an increase in the frequency of the pulse, but if when this takes place a large quantity of the drug be given the pulse is again lowered.

With this drug an intermission of temperature can be brought about when quinine fails.

A twelfth of a grain should be given in the form of a pill every two hours, until decided nausea and vomiting ensues. Four to six pills are usually enough. Its use has been advocated in pneumonia, the results of repeated cases shewing that there was a considerable lessening of the pulse and lowering of the temperature.

Dr. Ringer recommends that one or two drops of the tincture of veratrium should be given every hour.

Digitalis is a heart tonic, and increases blood pressure, sending a freer supply of blood to the skin.

But it is not a trustworthy drug, it is rather dangerous owing to its accumulative properties. It also interferes with digestion.

Its effect does not take place until about 36 hours after its first application; an interval too long for the drug to be of much use to us.

It is often advantageously combined with quinine when that does not produce a fall of temperature: ten to twenty grains should be gradually given during 24 or 36 hours and followed by a full dose of quinine.

A half an ounce to an ounce of the tincture may be given as a dose, and if the required effect is not produced repeated in 24 hours time.

Digitalis is counter-indicated in patients with a feeble heart and very rapid pulse.

Liebermeister says "The rule for its application is just the opposite to what it is in disease of the heart."

A few words may be said about the use of alteratives in fever. It is well known that a smart purge is of great benefit in the commencement of a febrile attack. Many German Physicians always begin their treatment of a case of fever by a dose of Calomel of about four grains.

The temperature may rise again, but often not to its original height.

Dr. Lauder Brunton attributes its action to its sweeping out of the duodenum with the fæcal evacuations, the ferments there and thereby diminishing the quantity in the blood. Less ferments getting into the blood, less oxidation will be carried on, and this may account for the fact that alteratives do not act sufficiently in the later stages of a febrile attack.

Much has been written and said as to the therapeutic value of alcohol, and Dr. Anstie and others have added much to our knowledge of the drug.

But it is not an antipyretic I would advise any one to use: the quantity required to be used is so large and the reductions of temperature following its use so slight that it will never be of much service: but as a cardiac stimulant in fevers it will always be of great benefit, and even then it must be used carefully. Its action is not lasting.

It acts (1) When absorbed into the blood by lessening oxidation and disintegration of tissues. (2) By dilating the capillaries and increasing the action of the heart and so causing an increased radiation of heat from the surface of the body. (3) By checking future fermentation.

Dr. Bing induced fever in dogs by injecting putrefying blood subcutaneously: some he left alone and they died with a high temperature; to others he gave alcohol diluted with water, the temperature kept low and they lived. He also asserts he reduced post mortem temperature by injecting alcohol.

Dr. Wilks says that the theory that alcohol tends to cure fever by antagonising fever is a mistake.

An exceedingly good and exhaustive account of alcohol, written by Mr. Carrington, was published in the *Gazette* about 18 months ago, to which I would refer you.

Alcohol must be given in large doses, ten to twelve ounces, to cause any reduction of temperature of any importance, and this must be frequently repeated. Small doses do no good; it also has no effect on persons innued to its use.

Broun Signard reckons opium, hydrocyanic acid, hyoscyamus, digitalis, belladonna, tobacco, euphorbium, camphor, acetic acid, oxalic acid, nitric, sulphuric and hydrochloric acids amongst the agents which reduce the temperature, but I think we have had sufficient for to-night.

HINTS FOR FIRST YEAR'S MEN.

Out of the large number of freshmen who present themselves at Guy's at the commencement of each sessional year, many without brother, relative, or friend here before them, find the first few weeks of their student life beset by many petty difficulties, small in themselves, but in the aggregate often causing much annoyance and loss of valuable time. To these a little well meant advice may not be out of place, and may, I am inclined to think, best be given by a senior student whose recollection of the difficulties he himself met with has not yet had time to become effaced. I shall endeavour, in the following remarks, to give just such details as my own experience tells me will be most useful.

The embryo Guy's man then will, as a necessary preliminary to his academical career, find his way to the Medical Office, and having paid the Dean his fees, should as soon as possible make himself acquainted with his surroundings. One important matter will demand immediate attention, the securing of a "part" for dissection. At Guy's, first year's men dissect the muscles and ligaments of the whole of the body, not as in some schools taking the whole of the structures of "uppers" and "lowers" alone. I need scarcely mention that the subject is divided into eight parts, two "head and neck," two "uppers," two "abdomen," and two "lowers." No choice as regards these is allowed the first year's man, who at the same time as he pays his hospital fees should put down his name for a "part," paying the stipulated price, usually 10/6. The freshman should on no account neglect this matter, as the supply of subjects is always uncertain, and a day's delay may mean a week or two of enforced idleness in the dissecting room, "parts" being always alloted according to priority of application. The student's further procedure with respect to his part will be alluded to later. This completed, registration next demands attention. As soon as he receives his card of admission to the school, the student should proceed to the College of Surgeons, Lincoln's Inn Fields, and to the Apothecaries' Hall, Blackfriars for this purpose, and should take with him his preliminary examination certificate, and his hospital card of admission. There is no registration fee. Registration must be completed before the 15th of October. The student will also be required to fill in at the School Office at Guy's a form of registration at the General Medical Council and must leave with this his preliminary certificate, which will be subsequently returned to him by the Janitor. Another matter now demanding attention will be the purchase of instruments, books, and other necessary articles. A case of dissecting instruments may be obtained from any instrument maker at an average price of from 15/- to a guinea. Mr. Millikin, of St. Thomas's Street, sells excellent instruments, and supplies most Guy's men. The case should contain 4 to 6 knives, a pair or two of scissors, forceps, chain hooks, needles, and blow pipe. An apron and sleeves will also be required for dissecting purposes, and may be obtained from the Injector at the dissecting room for a very moderate sum. The books required for the first winter will be those on Anatomy, Physiology, and Chemistry. These may be obtained at a discount of 25 per cent. at Gratton's, London Bridge, or Kimpton's, High Holborn. As regards the books to be selected from the numerous list presented for the student's approval, it is a little difficult to advise. I should, however, be inclined to say that Anatomy may best be learnt by a membership man from Gray and Heath conjointly, the former being used for systematic reading, and the latter as a companion in the dissecting room. For the London University or Fellowship student Ellis should take the place of Heath. The osteological part of Gray is complete and generally good, but his style is very didactic and the drawings of the bones mere diagrams. I should therefore advise all students who can afford a separate book of osteology to purchase Mr. Holden's very excellent manual. He has a peculiarly happy style of writing, and manages to present this usually dry subject in an extremely pleasant and readable form, whilst the plates are most admirable. The book is unfortunately somewhat difficult to obtain, as I believe no new edition has been published for some years. In default Wagstaff's Osteology is very good. In physiology, Kirke's is undoubtedly the most generally useful book for ordinary examinations. In chemistry, Roscoe's excellent little manual is most generally read, and is usually sufficient for all purposes. Fuller advice on this subject will be given by the lectures. However, whatever books you may select, always get the newest editions, it is only the falsest economy to purchase second-hand books in any of the subjects except perhaps osteology. Books and all other property will be kept in a locker, of which a series exists in two rooms adjoining the dissecting room. A key, carrying with it possession of one of these, may be obtained on payment of a deposit of five shillings to the Dean.

All these preliminaries being now disposed of and the First of October over, the freshman should at once settle down to regular work. This may be advantageously treated of under three heads: 1st, Lectures; 2nd, Dissection; 3rd, Reading. The courses of lectures for the first winter will be three, Anatomy, Physiology, and Chemistry. These should all be diligently attended. Do not fall into the error of regarding lectures as only a nauseous kind of medicine to be taken as seldom as possible. A course of lectures properly supplemented by reading is a most valuable means of gaining knowledge, but it is necessary that attendance should be regular, and that whilst in the theatre your attention should be entirely given to the matter in hand. Lectures irregularly attended are almost entirely valueless, as when present a man usually finds it quite impossible to take up the thread of a lecturer's discourse or feel any interest in what he hears. Inattention must follow, and is equally fatal to the student himself, and most annoying to the lecturer, and to men who wish to learn. The man who spends his time in the theatre in laughing at his own jokes, whittling the desks with his pocket knife, or reading the morning paper is more frequently voted a nuisance than he imagines. *Verbum sap.* Another point in connection with lectures, upon which junior students frequently enquire is the advisability or otherwise of note taking. This question is a somewhat difficult one to answer, as much depends upon the style of notes which the student is able to take, as well as upon the subject of the lectures. That a clear, concise series of notes is a valuable means of recalling to one's mind past lectures is no doubt true, but on the other hand it may be urged that the mechanical action of note taking too often takes the place of intelligent attention to the matter which the lecturer is endeavouring to impart. Again, so few students are able to seize quickly those salient points of a lecturer's discourse which are likely to be of use to them subsequently. On the whole I am inclined to think that the subjects of first years study (with perhaps the exception of Physiology) are not suitable for note taking. What may be called the more exact portions of the medical curriculum, such as Anatomy and Chemistry, appear to be the least valuable in the form of lecture notes. To digest a lecture efficiently pre-supposes also some acquaintance with the subject matter, and the object of lectures after all appears to be principally to impart in an easily comprehended form the first principles of sciences subsequently more fully followed up in books. Again it is most difficult to follow a professor's practical demonstrations and references to diagrams whilst rapidly engaged in taking down his words. Even in the case of physiology, in which from the constant changes and varying ideas on the subject a digest of the teaching of your own school is most useful I should be inclined to defer note taking until the second winter. Nothing, however, can be said against the practice of writing out after

a lecture as much of it as can be remembered. Classes will be held during the winter by the Demonstrators, and these especially must be diligently attended, as they are of the utmost importance. Leaving lectures, dissection next claims attention. It should be commenced as soon as ever a part can be obtained. A day or two after the student has applied for a part, as before advised, he will see his name amongst a list hung up in the dissecting room. As each subject is received the eight highest names on this list will be struck off and transferred to a card, which will have printed on it the names of the parts; each gentleman's name being on the same line as one of these, number one taking right head and neck, number two left ditto, and so on. The student should now keep a sharp look out upon this, and as soon as the subject is brought into the room this card will be suspended near its head, and without any further intimation he should at once commence work upon the part alloted to him. Advice upon the actual work of dissection would be out of place here. He will find some very practical remarks upon the subject in Heath, and the Demonstrators are always ready to render assistance, which the student should not be backward in asking for. He should read carefully the rules for the dissecting room, and adhere to them as closely as possible. Your Ellis or Heath should be constantly by your side, and as constantly referred to. If your part is a head and neck you should make an arrangement with your colleague on the opposite side for one to read as the other dissects, as it is almost impossible for two to dissect this part at the same time. If an "upper" or "lower" the part will require to be covered with a bandage, which, along with some tow, may be obtained from the Injector. Pad the limb well with tow, and then bandage it from below upwards as evenly as you can; artistic finish is not expected, so long as you cover the part thoroughly every purpose is served. This bandage must be gradually removed as you progress down the limb. After each day's work your part will require to be covered with glycerine or some other preservative fluid, and the skin to be sewn over it. Men have various methods of keeping their parts moist. Unquestionably the best is to stitch the skin closely over the dissection and then to lay on the glycerine freely *outside*. To apply glycerine directly to the dissection, as is almost always done, utterly destroys the natural appearance of a part. As soon as you receive one part apply for another, and if obliged to remain without a part spend an hour or two a day in the dissecting room listening to demonstrations and watching the dissections of others. If you receive a part which you have already dissected an exchange will always be made on application to one of the Demonstrators. Reading, as the final division of academical duties, next demands notice. Upon this point the best advice one can give is to begin at once, to read steadily, and to read upon a system. Above all things strive to get rid of the notion that reading is something only to be done with an immediate view to examination. Reading for examinations as it is generally understood is, I believe, a mistake. The man, who all through the year sticks steadily to his books but for a moderate number of hours daily, will face an examiner with far more confidence than his fellow who has done next to nothing for nine months and for three has been reading 12 or 13 hours a day. By all means then do not put off your reading until your second year or you will assuredly regret it. Have your fixed hours of reading at home, and adhere to these as strictly as you can. At the same time lay down certain subjects for certain times. You save an immense amount of time by system in this as in everything else. Reading should, too, as far as possible, advance *pari passu* with your other work. Always follow your lectures in each subject, and as far as possible the evening after they are delivered. To carefully read over your day's lectures in Gray, Kirke, and Roscoe will usually give you enough evening work. Your other reading is best done at the hospital. The getting up of regional anatomy is much facilitated by our unique collection of anatomical models. Care should be taken, however, not to regard them as in any way a substitute for actual dissection. Probably the best way of combining the two is as follows: read over carefully by the models every day a portion of Ellis or Heath corresponding to what will probably be the extent of your dissection on the morrow. In the dissecting room itself you will of course continually refer to the book by your side, and afterwards should, if possible, in the Museum, if not, at home, run over all you have dissected. A certain familiarity with the part will thus always precede actual dissection, whilst revision of your knowledge will at the same time never be lost sight of. Osteology, too, must be made a prominent, perhaps the most prominent, part of first year's study; at least two hours daily should be devoted to the careful study and re-study of the bones. If you can afford to provide yourself with a set of bones so much the better, if not, read in the Pathological Museum, with the aid of excellent specimens always to be obtained from the Museum Keeper. Much difficulty will doubtless be met with in osteology, which will only be overcome by constant repetition. Above all things draw your bones. Nothing tends to fix their geography in your mind so much as this plan; have red and blue pencils and mark the origins and insertions of muscles after Mr. Holden's excellent method. The roughest sketch will serve your purpose as well as an artistic drawing. Space will not allow me here to enlarge further upon this subject of reading, upon which experience will teach you much.

You will find it a most excellent plan to make a time table for your work of all kinds, both at the hospital and at home, and to adhere as closely to this as may be. It would be out of place for me to make any suggestion as to the arrangement of such a time table; much will depend upon individual circumstances, and relative knowledge of subjects. The time table should, however, be so arranged that no part of the hospital day is without its allotted task. Needful amusement should all be taken after you leave the hospital. Our authorities wisely recognise this principle, and give our students every faiclity for working all through the day and none for doing anything else. And again with a view of having all your work systematically directed to some useful end, permit me to give you a word of warning against a too common error of junior men, I mean going in for appointments during their first year. Assuming that appointments are a necessary evil to be got over in a perfunctory manner and as early as possible, this course is a wise one. Assuming, however, that they are a most valuable, I may say the most valuable, of the advantages of our hospital, the student will wait until he can utilise to the fullest extent the opportunities they give him of gaining a practical acquaintance with his profession. I venture to say that until his First College is over no man ought to take any appointment, with perhaps the exception of Surgical Out-patient Clerk. The man who is superior to the desire to see himself in office will many a time be rewarded for his patience by a dressership, whilst his over ambitious comrade is just floundering through his First College. In the same way you will be wise to keep away from the wards, the operating theatre, and the out-patient rooms, or at least only to look in at the last occasionally in the summer, or at other times when from some cause or other you are indisposed for more exact study. By acting otherwise you make a great mistake. You not only lose your own time to very littte purpose, but act a dog in the manger part to those senior men to whom every atom of practice is of the utmost importance, and who are in this way continually "crowded out" of the means of obtaining it. As a first year's man I received this advice from one of our lecturers, and have never regretted that I followed it implicitly. One other point should here be mentioned. At the end of the first year a voluntary examination is held, at which prizes and cer-

tificates of honour are given. Make up your mind to go in for these. Do not be deterred by the idea that only two or three men have a chance. Remember that the number of certificates is only limited by the number of men who obtain a creditable standard of proficiency. To gain a certificate, at once places a man amongst the *élite* of his year, attracts to him the notice of his superiors (always ready to discern merit), and paves the way for future advancement; besides the additional incentive given to your work will cause your efforts to be emphatically their own reward, and I am quite certain that whether successful or not you will never regret entering for a "voluntary."

Before concluding this paper I think it worth while to say a few words about recreation for the first year's man, and although it would be out of my province to go into the subject generally, to point out a few institutions connected with our hospital in which play may be given to varied tastes in this direction. There is then our ancient Physical Society associated with many generations of Guy's men, and to which every freshman ought to belong; he may find time to attend its meetings at least occasionly, and to prepare himself for speaking at them, and will here find a most useful means of coming in contact with his fellow students, and of expanding and ventilating his ideas. Every man, too, ought to subscribe to the *Guy's Hospital Gazette*, we are unique in possessing a journal of our own, and ought to support it freely. The *Student's Journal* also deserves mention. It is an admirable little paper, and contains much useful matter. To those inclined in an athletic direction the cricket and football clubs offer inducements, and even if you do not care for the games practically, it is worth remembering that were only playing members to subscribe, neither clubs could be maintained. Therefore become, if possible, a sedentary member at least. Those who wish for healthy exercise and agreeable companionship, without interference with their studies, cannot do better than join many of their fellow students in the 38th Middlesex Rifles. Those who are musically minded will in like manner find the Glee Club ready for them. One of our most esteemed lecturers in an Introductory delivered some years ago advised every student to select some one form of recreation and stick to it. Adopt his advice and remember that in student life as everywhere else "in the middle paths you will walk the safest."

You will find at Guy's every opportunity for making yourselves worthy members of the profession, and will, I am sure, never regret the day in which you entered our old *Alma Mater*.

The scraps of practical advice I have ventured to offer you, however crude or puerile, are at least well meant, and I trust that you will not think that in bestowing it I have too clearly borne in mind old Guy's motto "*Dare quam Accipere.*"

A MONTH'S OPERATIONS.

The following list of the principal operations performed in our theatre, during the last four weeks, cannot but prove of great interest to our readers; to old Guy's men, as showing that the number and importance of the operations have certainly not fallen off since their day; to freshmen, as giving them an idea what to expect in the future.

F. M., 28.—Pulpy disease of the knee-joint. Excision by Mr. Golding-Bird.
H. J., 7.—Suppurative disease of hip-joint. Excision by Mr. Bird.
J. W., 25.—Cleft palate. Staphyloraphy by Mr. Bryant.
R. W., 62.—Cyst of neck. Removal by Mr. Bryant.
A. C., 19.—Ostitis of lower end of tibia. Trephining by Mr. Bird.
C. S., 38.—Sarcoma below jaw. Removal by Mr. Bird.
E. E., 5.—Hip-joint disease. Excision by Mr. Howse.
J. O., 47.—"Charbon." Removal and chloride of zinc by Mr. Howse.
J. J., 24.—Neuroma (sarcoma ?). Removal by Mr. Howse.
C. H., 17.—Congenital hernia. Attempted cure by Mr. Howse.
T. T., 15.—Necrosis of tibia. Sequestrotomy by Mr. Colley.
J. P., 55.—Strangulated hernia. Herniotomy by Mr. Colley.
J. F., 62.—Strangulated hernia. Herniotomy by Mr. Colley.
J. D., 6.—Calculus vesicæ. Lithotomy by Mr. Lucas.
S. T., 52.—Carcinoma mammæ. Excision by Mr. Lucas.
E. M., 10.—Tetanus after excision of knee. Amputation by Mr. Bird.
A. T., 20.—Periosteal sarcoma of femur. Amputation through hip by Mr. Lucas.
H. W., 7.—Hip-joint disease. Excision by Mr. Bird.
F. W., 32.—Pulpy disease of knee-joint. Excision by Mr. Bird.
C. N., 30.—Papilloma of penis. Amputation by Mr. Bird.
J. D., 42.—Varicose veins. Ligature by Mr. Howse.
C. R., 22.—Disease of hip-joint. Excision by Mr. Colley.
J. C., 7.—Cleft palate. Staphyloraphy by Mr. Howse.
A. S., 4.—Rickets. Subcutaneous osteotomy of both tibiæ by Mr. Howse.
J. R., 19.—Cleft palate. Staphyloraphy by Mr. Howse.
C. C., 59.—Irreducible hernia. Herniotomy by Mr. Colley.
E. P., 16.—Disease of ankle-joint. Excision by Mr. Colley.
A. B., 8.—Compound fracture at knee-joint. Amputation by Mr. Bird.
F. R., 50.—Ununited fracture of tibia. "Pegging" by Mr. Colley.
J. B., 52.—Sarcoma of superior maxilla. Excision by Mr. Howse.

ROYAL COLLEGE OF SURGEONS.

We make the following extract from the report from the Court and Board of Examiners of the number of candidates who have presented themselves for the Primary and Pass Examinations for the diploma of Member of the College during the collegiate year 1876-77, showing the number who have passed and have been rejected from each medical school during that period.

PRIMARY EXAMINATIONS.
1876-77.

Medical School.	Totals.	Number passed	Number rejected.
St. Bartholomew's	119	82·50	36·50
University College	100.50	69	31·50
Guy's	80	70	10
St. Thomas's	60	38·50	21·50
London	42·16	24·3	17·83
St. George's	40·6	26·3	14·3
King's College	33·50	24·50	9
St. Mary's	27·50	18·50	9
Middlesex	24	20	4
Charing Cross	20·6	15·3	5·3
Westminster	11	8	3
Manchester	35·50	23·50	12
Liverpool	30·50	25	5·50
Bristol	23	8	15
Birmingham	21	15	6
Sheffield	7·50	3·50	4
Cambridge	9·50	7·50	2
Dublin	20·50	7	13·50
Edinburgh	25	18·50	6·50
Glasgow	4	2	2
Aberdeen	·50	·50	...

PASS EXAMINATIONS.

1876-77.

Guy's	83	...	68	...	15
St. Bartholomew's	72	...	63	...	9
University College	64·3	...	51·3	...	13
King's College	45·50	...	32·50	...	13
St. Thomas's	42·6	...	32·6	...	10
St. George's	27	...	24·50	...	2·50
London	26	...	19	...	7
St. Mary's	19.3	...	14·50	...	4·83
Middlesex	15·16	...	11·3	...	3·83
Charing Cross	7·83	...	6·50	...	1·3
Westminster	7·83	...	3·83	...	4
Manchester	25	...	18	...	7
Birmingham	24	...	19	...	5
Liverpool	10·16	...	4·83	...	3·3
Bristol	9·50	...	4	...	5·50
Cambridge	3·50	...	1·50	...	2
Sheffield	2	...	1	...	1
Dublin	9·50	...	5·50	...	4
Edinburgh	23·16	...	13·3	...	9·83
Aberdeen	5·3	...	4·3	...	1
Glasgow	1	...	1	...	...

NOTE.—In these respective lists candidates who are indicated by a fraction have received their education at more than one school of medicine.

Calculating from the above list, the percentage of rejections from the chief metropolitan schools stand thus:

Pass Examination. St. George's, 7·4; St. Bartholomew's, 12·5; Guy's, 16·14; University, 20·3; St. Thomas's, 23·8.

Primary Examination. Guy's, 12·5; St. Bartholomews, 30·2; University College, 31; St. Mary's, 33·3; St. Thomas's, 35; St. George's, 35.

It will thus be seen that Guy's easily heads the list in the case of the Primary, while it stands third in the Pass list; it must be remembered, however, that in this latter case St. George's only sent up 27 men, against 83 from Guy's, and 72 from St. Bartholomew's.

NOTES OF THE MONTH.

Sir William Jenners state that in Carcinomatous and Tubercular disease of the Peritoneum though no tubera could be felt over the general abdominal surface, a careful examination around the Umbilicus would generally reveal some deposit, most probably due to extension of the disease up the course of the obliterated umbililical vessels.

Continous pain on the vertex, especially if accompanied by tenderness on pressure, is generally, if not always, diagnostic of some nervous debility or hysteria.

Pain in the head is rarely found in simple epilepsy; and if constant, is indicative of some cerebral mischief, as tumour, being the cause of the fit.

Mr. D. ELCUM has recently passed out from Netley into the Indian Medical Service, fifteenth on the list.

A Guy's Student, entering his fifth year, is desirous of recommending Apartments in the house where he has lived the last two years, in the neighbourhood of Kennington, a nice walk from the Hospital, and suitable for a reading man. Apply, 35, Lorrimore Square, Kennington, S.E.

Apartments well furnished for gentlemen where every attention is given to make them comfortable. 53, Great Dover Street, Borough.

STATISTICAL REPORT OF LYING-IN CHARITY FOR AUGUST, 1877.

Number of women attended				213
Recovered		213		
Died		0		
		213		
Single Births				208
Dual				5
				213
Women attended in 1st confinement				33
„ „ 2nd „				30
„ „ 3rd „				21
„ „ 4th „				28
„ „ 5th „				27
„ „ 6th „				18
„ „ 7th „				17
„ „ 8th „				17
„ „ 9th „				9
„ „ 10th „				8
„ „ 11th „				3
„ „ 12th „				2
				213
Children at full time.				
Males alive		93		218
Males dead		1		
Females alive		121		
Females dead		3		
Total number of children				218
Alive		214		218
Dead		4		
Presentations.				
Vertex			208	
Breech			5	
Foot			2	
Shoulder			1	
Vertex and Hand			1	
Brow			1	
			218	
Operations.				
Version	1			
High Forceps	1			
	2			
Externs attended.				
Mr. J. T. Brett				23
Mr. J. S. Crook				54
Mr. Cortis				34
Mr. Bryden				32
Mr. B. Studor				70
				213

ALFRED G. BARRS,
Junior in Charity.

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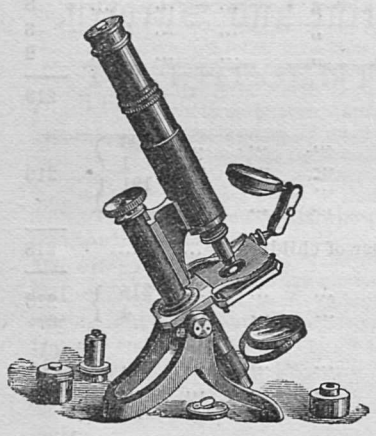

IMPORTANT NOTICE—JULY, 1877.

It having come to the knowledge of Mr. James Swift, of University Street, London, that one of his registered Microscopes, similar to illustration, has been pirated, J. S. begs to caution all purchasers of Microscopes against these spurious imitations, which are of exceedingly inferior workmanship. As a greater precaution against this imposition, J. S. has appropriated a *Trade Mark*, a facsimile of which is herewith shown, which will be engraved upon every Instrument and important optical appliance which leaves his Establishment after this date. J. S. further begs to caution purchasers against buying second-hand Microscopes and Objectives bearing his name, as an unwarrantable liberty has been taken in affixing his name to such articles, and J. S. will have no objection to inspect, free of charge, any such Instruments or Objectives, to ascertain whether they are genuine.

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Rack and pinion coarse adjustment can be adapted to this Instrument in place of sliding tube, extra £1 10s.

THE ABOVE MICROSCOPE

Has lately been improved by the suggestions of Prof. Rutherford, Edinburgh University, to which College it is supplied; and is strongly recommended by Dr. Pye-Smith, Guy's Hospital, London; Prof. McKendrick, Glasgow; Dr. Lionel Beale, King's College; Profs. Brown and Axe, Royal Veterinary College, London; Prof. Bommer, University, Brussels; &c., &c.

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Guy's Hospital Gazette.

A Students' Journal of Hospital News, Medicine and Surgery.

NEW SERIES.—No. 23. NOVEMBER, 1877. SIXPENCE.

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Kirke's Handbook of Physiology	(14/-)	10/6
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Wagstaffe's Guide to Human Osteology	(10/6)	8/-
Ward's Human Osteology	(7/-)	5/3

&c., &c., &c.

Students Note and Case Books in great variety.

Among the forthcoming works to be published by Messrs. Churchill, we see announced, one by Dr. Galabin, "Guide to the Diseases of Women."

Videas mea posteriora.—Dr. Johann F. Teller was one day holding an argument as Majisterlegens, in Leipsig. His antagonist, Dr. Schumann, had managed neatly to pin him in a corner, when Teller, in a state of high excitement, cried "*Videas mea posteriora!*" Indignantly Schumann turned to the Dean with these words "*Hac obscornitate academica nihil unquam turpius vidi.*" The Dean, of course, expostulated with Teller, requesting him to withdrawn his injurious expression; whereupon the latter explained that by "*posteriora,*" he intended to be understood the corollary at the close of his argument.

Micoscrope for Sale. Monocular, by Pillischer; 1 inch and $\frac{1}{4}$ inch; 2 eye pieces; condensor, live box, double nose-piece, &c., &c. Well suited for histological purposes. Apply to Betts, at the Museum.

The Practitioner. Clean Copy of January, 1876, wanted. Full price. Betts, Museum.

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Medical and Surgical Practice in London.

HOURS OF ATTENDANCE OF STAFF.

Hospital.	Medical. Daily.	Surgical. Daily.	Obstet.	Ophthal.	Dental.
Charing Cross ...	1 p.m.	1 p.m.	Tu. F. 1.30	...	M.W.F., 9
Guy's	1.30 p.m.	1.30 p.m.	M. W. F. 1.30.	M.Th. 1.30 Tu. F., 12.	Tu. Th. F. 12
King's College ...	2 p.m.	1.30 p.m.	M. W. F., 1 p.m.	M.Th.,S.1	Tu. F., 10
London	1.30 and 2 p.m.	1.30 and 2 p.m.	...	W. S., 9	Tu., 9
Middlesex	1.30 p.m.	1 p.m.	M.W., 1.30	Tu.F., 8.30	Daily, 9
St. Bartholomew's	1.30 p.m.	1.30 p.m.	M. Th., 2 W. S., 9.	Tu.Th.S., 1.30.	Fr., 9
St. George's... ...	1 p.m.	1 p.m.	Th., 2.	W. S., 2	Tu.S., 9.30 Th., 1.30
St. Mary's	1.15 p.m.	1.15 p.m.	Fu.F., 9.30	M.Th. 1.30	W.S., 9.30
St. Thomas's ...	8.45 a.m.	8 a.m.	W.F. 12.30	Daily, 2, ex. S.	Tu. F., 10
University College	1.15 and 2.30 p.m.	1.30 and 2 p.m.	Daily, 1.30 ex. W. & S.	M. W.F., 2	W., 10.30
Westminster ...	1.30 p.m.	1.30 p.m.	Tu. F., 3.	M. Th., 3	W. S., 9·15

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If addressed to the Hospital—5/.

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All communications for insertion should be addressed to the Editor.

Country Subscriptions, Advertisements, and Business Communications, must be sent to C. K. Shaw, Esq., Guy's Hospital, to whom Post Office Orders, should be made payable at the Post Office, Borough High Street, S.E.

CASE OF TETANUS.

(*Continued from page* 111.)

September 20th.—Bowels have been well opened, and he is in consequence much easier. Has slept well. Can move his legs more freely. Spasms less frequent, is in fact altogether better, though his temperature still remains high. 10 a.m.—Temperature, 102·8°; pulse, 110. Morphia gr. ½-⅓. 4 p.m.—Temperature, 102·6°. 10 p.m.—Morphia gr. ½-⅓.

September 21st.—Is not so well in himself, though there has been no return of the spasms. His temperature has again gone up, and his breathing is hurried and shallow. There is want of resonance over whole of back, though no absolute dulness nor sign of actual disease. Tongue, dry and foul; sordes on lips. Morphia to be stopped. Quiniæ Sulph. gr. v. t. d.s. Wine 4 oz. 10 a.m.—Temperature, 103·9°; pulse, 118; respiration, 36. 4 p.m.—Temperature, 103·7°; pulse, 110; respiration, 36. 9 p.m.—Temperature, 102·6°: pulse, 106; respiration, 36.

September 22nd.—Better night on the whole; delirious at times. More easy in himself. Tongue moister. Takes his food well. Breathing about the same. 10 a.m.—Temperature, 103°; pulse, 108; respiration, 40. 4 p.m.—Temperature, 102°; pulse, 120; respiration, 36.

September 23rd.—Has not slept at all, and has been very delirious. Had some doses of the Mist. Gin. Vallici, which seemed only to excite him the more. 10 a.m.—Temperature, 101·7°; pulse, 108; respiration, 40. 9 p.m.—Been very delirious all day. Morphia ½. Beef-tea, lemonade, wine, quinine gr. v.

September 24th.—Has had about an hour's sleep during the night. Is now very drowsy, and has some difficulty in swallowing. Spasms have entirely ceased. To discontinue the Mist. Gin. Vallici. 10 a.m.—Temperature, 99°; pulse, 88; respiration, 28. 4 p.m.—Temperature, 99°; pulse, 100; respiration, 32. 9·30 p.m.—Morphia gr. ⅓. 12·30 a.m.—Morphia gr. ⅓.

September 25th.—Is somewhat better this morning. Talks rationally, and is very cheerful. Slept after second injection for an hour or so. Swallows better, and is not so excited by the wine. No return of spasms. Still goes on with the quinine. 10 a.m.—Temperature, 100·2°; pulse, 104. Quinine gr. v. 4 p.m.—Temperature, 99·6°; pulse, 104; respiration, 28. 9·30 p.m.—Morphia gr. ⅓, quinine gr. v.

September 26th.—Has had a much more quiet night, though slept but little. Is stronger and more cheerful. Takes his food and wine well. No spasms. 10 a.m.—Temperature, 101·4°; pulse, 104; respiration, 24. Quinine gr. v. 4 p.m.—Temperature, 101°; pulse, 110; respiration, 24. 9·30 p.m.—Temperature, 101°. Has been restless since last note, and very sick. Morphia gr. ⅓.

September 27th.—Is not so well this morning; has been very sick, and is much weaker. Could not keep his breakfast down. Quinine to be stopped. 20 a.m.—Temperature, 101·6°; pulse, 120; respiration, 32. 4 p.m.—Temperature, 102·4°; pulse. 120; respiration, 36. Has not kept anything down during the day. 9·30 p.m.—Temperature, 101·6°. Restless and wandering. Morphia gr. ⅓.

September 28th.—Has passed a very restless night, and seems now almost in *articulo mortis*. He is lying sunk down in the bed, with eyes half open, in a low muttering delirium. Is unable to keep any food down. No spasms. Creasoti ♏j. in form Pil. Ol. Ricini ʒj. Ol. Limonis iii. Mist. Mucilag. ʒj. A tablespoonful at a time. Brandy. Temperature, 101·6°; pulse, 120; respiration, 40. 4 p.m.—In the same state. Temperature, 102·2°; pulse, 110. 9 p.m.—Pulse, 135; weak and fluttering. Bowels well opened, but sickness continues. Morphia gr. ⅓.

September 29th.—Has had a wretched night; no sleep, and constant vomiting. Low muttering delirium. Hands blue and cold. Cannot swallow. 10 a.m.—Temperature, 101·6°; pulse, imperceptible; respiration, 50. 4 p.m.—Died quite quietly.

At the post-mortem examination nothing was found to account for death. The spinal cord and brain were taken for further examination by Dr. Goodhart.

A. Scott.

CASE OF MALIGNANT PUSTULE.

J. O., æt. 47, was admitted into Naaman Ward, under Mr. Howse, on September 4th, 1877, suffering from a hard circumscribed swelling on the right cheek and enlargement of the glands in the right side of the neck, with much febrile constitutional disturbance.

Patient gave a very good family and previous personal history He had never had syphilis nor skin disease of any description. He had latterly been working in a tannery, and stated that he had known many men in the same employment to have been affected with a similar complaint to his own. For the fortnight previous to admission he had noticed a small pimple on his right cheek, about an inch and a half from the angle of the month; this had remained unchanged till August 30th, when he observed that it was becoming larger.

On September 1st it had increased to the size of a threepenny-bit, and small vesicles had begun to appear upon it; the patient began to feel ill, had frequent attacks of sickness and shivering, and at the same time noticed a swelling commencing beneath the jaw. During the two following days all these symptoms became exaggerated, and a constant dull aching pain was felt in the cheek.

On admission.—Patient was a stout unhealthy-looking man, his face much disfigured by a large swelling beneath the right side of the jaw, and a circular raised

patch of inflamed tissue on the right cheek. This latter was about the size of a florin and raised about $\frac{1}{8}$ of an inch from the surrounding skin; it had a peculiarly tough leathery feel, and its surface was covered with minute vesicles, discharging serum, but no pus; it was slightly reddened, but there did not appear to be much local elevation of temperature, nor was the surrounding skin at all inflamed or indurated. The mucous membrane of the mouth was free from any attachment to it posteriorly. No sharp pain was complained of but only a dull aching, both in the tumour and in the swelling in the submaxillary region. Tongue furred. Bowels constipated. Pulse, 100; temperature, 101·2°.

Soon after admission to the ward chloroform was administered and the tumour completely removed by a circular incision, the skin and a little subcutaneous fat alone being taken away. The wound was then freely cauterized with chloride of zinc paste. 10·30 p.m.—Patient complained of burning pain in the wound, but otherwise feels better. Pulse, 100; temperature, 100·8°. Was given Inject. Morph. gr. $\frac{1}{3}$.

September 5th, 10 a.m.—Free from pain; swelling in neck decreasing in size. Some œdema of right lower eyelid. Surface of wound covered with dry, black eschar. Constipation continued. Pil. Cal. c. Col. gr. x h.n. Pulse, 89; temperature, 100·4°. Evening temperature, 99·2°; pulse, 104.

September 6th.—Patient much relieved after free action of bowels. Had occasional sharp shooting pains in neck. Œdema of eyelid less marked. Pulse, 72, intermittent; temperature, 97·6°. Ordered Tr. Ferri Perchlor. ℥xx. Tr. Opii ℥viij. Mist. Quinæ. ver. ℥j. 4 tis horis.

September 7th.—Had vomiting after taking quinine mixture. Complained of general aching, especially about epigastrium and down the left side. Pulse, 100; temperature, 98·4°. No alteration in the appearance of the wound: a hard, brawny ridge could be felt encircling it, probably due to commencing inflammatory action in the healthy tissues. Swelling in neck much decreased in size. Bowels open freely. 10·20 p.m.—Had further sickness after taking quinine. Countenance pale and with an anxious expression. Complained of pain in left side of abdomen, but could not indicate any particular spot; abdomen distended. Occasional cramps in thighs. Pulse, 98; small, but regular. Slight shivering at times. Extremities cold. During the night, and till about 10 p.m. on September 8th, patient continued in the same state. Free stimulation by brandy and ammonia being resorted to. A sudden attack of dyspnœa took place about 2 p.m. Patient complained only of general abdominal pain, and had no sensation of chocking. Pulse became gradually weaker; there was profuse sweating, but extremities remained cold. Patient retained consciousness till just before his death, which took place about 5 p.m.

P.M. 47 hours after death (by Dr. GOODHART).—Body was much decomposed. All the veins about the seat of the pustule were free from embolism or pus. The only evidence of extension of the disease was a swollen and intensely congested gland above the right submaxillary gland. Brain, membranes, sinuses, and bones of skull perfectly healthy. Both lungs nearly solid at bases from want of expansion. Arteries and veins good and normal. Heart healthy. Liver, spleen, and kidneys much decomposed but healthy. No general peritonitis. Over surface of small intestine, two or three patches of very intense ecchymosis about 3 inches in length. No enlargement of mesenteric glands. Tonsils thickened and decidedly congested. Œsophagus healthy. Slight thickening of the mucous membrane of the stomach in two places, hard and fleshy on section, and covered with a layer of blackish blood. Small intestine healthy internally, with the exception of the patches in the ilium previously noticed. These were all at the mesenteric attachment of the bowel, and separated by about 18 inches of perfectly healthy intestine. The mucous and submucous tissues were thickened and congested and covered with blackish blood; the valvulæ conniventes raised, hard and fleshy on section but not containing pus. The mesentery was also much thickened. There was no pus anywhere. Area of Peyer's patches altogether unaffected. Solitary glands not enlarged. Lower down in the ilium were other patches resembling those in the stomach. The condition may fairly be described as one of "charbon of the intestine." Cæcum and large intestine healthy. Thickened mesenteric tissue under the microscope showed numerous pyoid corpuscles crowding the alveolar and fatty tissue.

MENTAL DISEASE?

What is rational belief, and what is irrational? What amount of deviation from the mode of thought and action of society is sufficient to constitute a mental disease? These questions are frequently asked, but never satisfactorily answered. Indeed, no two ages, no two individuals, are likely to agree as to the answer to be rendered. Perhaps a general response is impossible: certainly the most satisfactory method is to deal separately with each specific aberration, and decide whether it merits to be treated as a disease of the mind, or merely as a harmless eccentricity.

It has frequently been argued that the modern phenomena, known under the name of spiritualism, constitute a species of insanity; at any rate, of monomania. The question is one fully deserving of the careful investigation of men in the medical profession competent for the work. It would be impertinent for the present writer, who is not in that profession, to make any such attempt. The only object aimed at in this article is to point out the curious resemblance that exists between the phenomena of spiritualism and those

of the old, and now happily extinct, crime of witchcraft, in the hope that the facts pointed out may be of use to some persons better qualified to conduct the more intricate investigation. For this purpose the *actual existence* of the phenomena is unimportant, all that is necessary is the *belief* in their existence.

Perhaps one of the most curious coincidences between the two classes of phenomena is the condition of national thought upon which they have grown; perhaps to which they owe their existence. The popular belief in witchcraft sprang up with the Reformation, when society deserted the quiet ruts of Catholic belief to jolt uneasily across untrodden ways towards religious liberty. But a sudden liberation from serfdom rarely results in the freedom acquired being used in the most prudent manner, and consequently the history of the times teems with the most extraordinary instances of political and religious vagaries. In our own times religion appears to be again settling down from free-thought into formula, and leaving to modern science the duty of effecting a new Reformation; and it is in this condition of things that spiritualism has sprung into being.

In considering the actual parallels between the two beliefs, want of space makes it necessary that only three points of resemblance should be noticed; to point out all the analogies would involve writing a book. The three that have been chosen are these:—the powers of (1) levitation; (2) supernatural knowledge of occurring or future events; and (3) speaking unknown tongues, were possessed by persons demoniacally possessed, and are claimed by spiritualistic mediums.

1.—As to levitation. Mrs. Guppy was anticipated in her extraordinary performances by the unfortunate beings who are represented by the weird sisters in "Macbeth," who utter their fatal prophecies and then vanish; only, in those days, the performance had no scientific name, but was known as "broomstick riding." Witches were always transported in this manner to the Sabbaths they attended, frequently through long distances, undeterred by bricks and mortar, in a manner which even Mr. Home might envy. It would appear that Colonel Lovelace was physically, as well as sentimentally, correct when he wrote—

> "Stone walls do not a prison make,
> Nor iron bars a cage."

2.—As to supernatural knowledge of events. John Cotta, a physician of some eminence towards the close of the sixteenth and the commencement of the seventeenth centuries, investigated the phenomena of possession, mostly in cases that came under his professional care, and published the result in a book called "Tryal of Witchcraft," in 1601. In it he makes the following remark:—"Some sicke men have also revealed and declared words, gestures, and actions done in farre distant places, even in the very time of their acting, doing, and uttering." It would be waste of time to instance modern examples of this power. Nearly everybody has an acquaintance who has been to a medium, to whom he fancied himself an utter stranger, and has been startled at being accosted by name, and by being informed of events that have just transpired and which could not possibly have come to the medium's knowledge by natural means.

3.—The gift of tongues. Perhaps this is the most extraordinary coincidence of all. The physician just quoted says that the possessed "in the time of the exacerbations of their fits have spoken languages knowingly and understandingly which in former time they did never know, nor could afterwards know again." Ben Jonson, who was never tired of making fun of the popular beliefs, in his play "The Devil is an Ass," makes a supposed maniac ejaculate in Greek, Italian, and French; a piece of evidence that convinces the judicious Sir Paul Eitherside that "It is the devil by his several languages." It is curious that a power, supposed two centuries and a half ago to arise purely from diabolic intervention, should now be attributed to the action of good spirits; yet so it is. The author of a most extraordinary book, called "The Holy Truth," Mr. H. J. Browne (1876), says, evidently in good faith, "On another occasion Mr. Foster gave me a message from an old friend in the Kaffir language. * * * * In the message were connected names of Europeans with those of natives, in such a way, and referring to particular occurrences, that it was utterly impossible for any one but the parties themselves, or their spirits, to have described. Mr. Foster then asked me what kind of language it was that he had been speaking, and when I told him it was Kaffir or Zulu, he said he had never heard such a language before."

Here these remarks must cease. It would be idle for a layman to indulge in *a priori* speculations without the knowledge necessary to test them. It is possible that future investigation may reveal facts concerning the working of the mind that have hitherto eluded the vigilance of our physicians. At any rate a consideration of the historical bearings of the question cannot be entirely out of place. It is only necessary to add, in conclusion, that nothing has been said about the phenomena of spiritualism that any person believing in that doctrine would not maintain as absolutely indisputable.

PHILOSOPHICAL PHYSIOLOGY.

A notion is very current just now, among certain would-be philosophical physiologists, that thoughts, emotions, and volitions are secreted by the brain, just as saliva is secreted by the parotid. Now, I think, that this notion is as contrary to philosophical fact as to metaphysical reasoning. Accordingly, I shall leave the metaphysics alone, for the present at least, and betake myself to physiology.

Now, from all that has hitherto been observed, I think, we have no evidence that nerve centres ever *originate* action. Their function seems to be always reflex. They receive

impressions, either from their afferent nerves or from other centres, and, so to say, act upon them. Take an animal which has been recently decapitated. The centres in the cord are still capable of functional activity, but the animal lies motionless. Let some irritation be applied to the afferent nerves, and there is at once movement. The action is automatic, not spontaneous. It might appear, however, to a superficial observer, that some actions, which are performed continuously, and without the aid of volition, are originated spontaneously by the nerve centres—as, for instance, that respiration is originated by the medulla oblongata. But, if the afferent nerves which convey the impression of "*besion de respirer*" are divided, respiration ceases. This is plainly because the medulla oblongata cannot spontaneously supply the nervous force which excites muscular action. Its function is purely reflex. Some actions again are produced by nerves centres in obedience to impulses derived, not from peripheral nerves, but from other nerve centres. It appears that the voluntary movements of the limbs are produced by the centres in the cord, acted upon by the higher centres in the brain, especially the corpora striata, which are themselves dependent for their stimuli upon the convolutions. But what acts upon the nerve cells of the convolutions? Those theorists who belive in nothing which they cannot see (or think they see) suggest that, as we cannot see anything higher than the centres in the convolutions, we must assume that the molecular changes therein are the primary origin of all actions which are not the direct result of stimuli acting on peripheral nerves. But what right have we to assume that the grey matter in the convolutions is capable of a function which is wholly different, not in degree merely, but in kind, from any which is discharged from all other grey matter?

So then, after all, physiology leaves us with the great mystery of the origin of volition still unsolved, or solved only by a guess. And men could guess about it well enough before nerve cells were heard of. Nor can I see that the physiological guess is more satisfactory than any other. It seems to be simply this. *Perhaps* the convolution centres can do, somehow, a thing that we are aware no other centres can do the like of; and yet we have no evidence that the centres in the convolutions are in any essential particular different from the rest.

But, if we do not accept this physiological guess, we must admit an explanation of the phenomena which removes the question from the domain of physiology altogether—a mode of solving the difficulty which is very objectionable to certain physiologists. Indeed, I suspect that the "nothing-like-leather" principle is at the bottom of a good deal of so-called scientific materialism. But have we anything like physiological evidence of the existence of any "primum mobile" which is above grey matter? I think there is, at least, a suggestion of such a thing.

I read awhile ago some experiments (which I have not space to describe) which prove that the stimulus of external impressions is necessary to the maintenance of the waking activity of the brain (*i.e.* impressions derived from something *external to the brain*, not necessarily external to the animal). But if a man places himself in such circumstances as to exclude, as far as possible, impression upon his senses, he may still be kept awake by earnest thought, *i.e.* by a *psychical* stimulus to his brain. Then the *psyche* must needs be something external to the brain. And, so far as the brain is concerned at all in the manifestation of mental activity, its function is merely reflex, and not spontaneous. The facts of our consciousness (whatever hasty theorists dazzled with the brillance of a wide generalisation may say) compel us to admit the existence of a "certum quid" which uses grey matter for a while as the instrument whereby in acts upon other matter—an instrument which it can lay aside and dispense with when broken or worn out.

I do not know whether any thought here is original. I probably have not produced anything very profound. But I shall not have wasted my time if I have done anything to preserve any tryo in physiology who is learning to think, from the shallow notion that wisdom and folly, love and hatred, and above all, conscience, are nothing more than functions of nerve cells. F.C.C.

NOTES FROM THE WARDS.

Mr. Cooper Forster.

In the prefatory remarks appended last month to the notes from Mr. Howse's wards, the value of the antiseptic treatment was put forward, and the cases related gave instances of its influence in the arrest of constitutional disturbance. Cases from Mr. Forster's wards, where Lister's treatment is in some instances adopted and in some not, prove the immense advantages to be derived from that method. Until lately one might see in these wards, side by side, examples of the two methods of treatment; but, within the last few months, the number dressed antiseptically has largely increased, so evident has become the superiority of that mode of dressing.

Not the smallest advantage is the entire absence of fœtor from discharges, even when the dressings have not been changed for two or three days. What an incalculable blessing it is that a ward may be full of operation cases and yet not one of them suffer from any offensive odour emanating from a neighbouring wound.

The treatment certainly has some small disadvantages, but, such as they are, they can never outweigh the immunity obtained from pyæmia, from severe traumatic fever, and from fœtid discharges.

CASES IN LUKE.

No. 1.—Case of infantile hydrocele, occluded at the internal ring. Incised on August 10th. The boy is now getting up, the wound being nearly healed. Dressed antiseptically. (Compare Mr. Jacobson's recent article in *Brit. Med. Journal.*)

No. 6.—Herniotomy. Man ruptured since 12 years old. Was in Guy's 15 years ago, when the hernia was reduced under chloroform. Hernia came down on September 8th, and could not be reduced. Admitted on the 9th with symptoms of strangulation and a large scrotal hernia. A great part reduced under chloroform; but, as a knuckle remained strangulated, the cutting operation was performed. Sac opened, and surfaces brought together to procure, if possible, its obliteration by inflammation. Operation performed antiseptically. Patient doing well.

No. 8.—Excision of knee, performed for bony anchylosis at an angle of about 120°. As the patella was united by bone to the femur, it was found necessary to saw though the ends of the long bones before the joint could be opened.

No. 11.—Boy, æt. 14, fell across a plank day before admission. Immediately after could not pass his water, but did so next morning, much blood coming with it. There was much swelling and ecchymosis of perinæum and scrotum. As there was no constitutional disturbance he was simply kept quiet in bed and a No. 3 catheter passed, which went in easily. Two days after admission, as there was much pain, two incisions were made in the perinæum and a large blood-clot turned out. The urethra was found to be ruptured to the extent of

1¼ inch, and it was with great difficulty that the catheter could be made to reach the bladder. The boy has done uninterruptedly well since.

No. 13.—Ununited fracture of upper third of right tibia and fibula of 18 months standing; fibrous union only. It is proposed to peg together the ends of bone with ivory.

No. 21.—Acute periostitis of left tibia; no cause assigned. A large portion of the shaft of the tibia necrosed. Secondary inflammation of ankle-joint and in cellular tissue of thigh.

CASES IN CHARITY.

No. 1.—Syphilitic bone disease. Lardaceous viscera. Suffers from severe pain in stomach.

No. 3.—Pulpy disease of ankle, traced to an injury 4 years age. Has not been able to walk for 3 months. Excision of joint.

No. 7.—Irreducible omental hernia of 30 years standing. Wears a truss. Suffers from periodical attacks of pain in tumour, with increase of size, and from sickness. There evidently being at these times some increased constriction. Operated upon antiseptically. Sac opened; omentum ligatured and cut off; walls of sac brought together. Patient doing well.

No. 10.—Amputation of second toe at metatarsal-phalangeal joint. Antiseptic dressings. Primary union.

No. 13.—Non-impacted fracture of neck of left thigh in an old woman æt. 63. The fracture appears to pass through upper part of trochanter.

No. 14.—Penetrating wound of abdomen, 2½ inches long, to right of and below umbilicus. Protrusion of 2 feet of intestine, which was uninjured. Intestine returned and wound sewn up. Not a trace of peritonitis. Antiseptic dressings.

Cot 28.—Refracture of malunited fracture of femur.

No. 19.—Interesting case of enterotomy. Child 4 days old. Said to have passed one motion. Fæcal vomiting and much emaciated. Catheter passed through anus for about 3 inches, but seemed then arrested. Abdomen opened in right groin, and first piece of intestine which appeared, secured to the skin, and then opened. Free passage of meconium. Child improved very much, but on the second day sank and died. P.M.—Intestine entirely occluded about 9 inches above the cæcum, which was just below the point where the intestine was opened; so that, unwittingly, the operation had been performed at the most advantageous spot possible. Below the occlusion the intestine was continued as a narrow passage, unstained by meconium, to the anus. Above it was much thickened and distended.

CORNELIUS.

No. 10.—Case of tetanus commencing 2 days after a superficial quicklime burn on the foot. At the time of writing this, the spasms have lasted 14 days and show signs of improvement. Treated with subcutaneous injections of morphia (¼ grain) every 3 hours. Calabar bean was tried, but the patient appeared to become worse whilst using it.

Correspondence.

To the Editor.

Dear Sir,

I shall be greatly obliged if, through your columns, you will allow me to mention a fact of some import, *i.e.*, I have noticed in our comparative anatomy museum that some of the waxwork dissections are suffering from the vibration caused by heavily laden waggons passing through Maze Pond. If india-rubber discs were placed beneath the table legs, I fancy much would have been done to preserve those valuable specimens.

Yours truly, S. S. B.

THE UNITED GUYITE CLUB.

"In Unitate Robur."

The tenth annual dinner of this club was held at the Criterion, Piccadilly, on the 1st of October, when the following members were present:—Drs. Brailey and Savage, Messrs. John Burroughs, George Coombe, E. Forbes Gaitskell, Alfred Gillingham, R. Clement Lucas, H. Moon, Francis Seymour, Charles Seymour, E. F. Thomas, W. C. Toulmin, Charles Ticehurst. In the course of the evening Messrs. R. N. Coombe and G. T. B. Stevens were elected members.

The following letter will be read with interest by members of the club.—

Constantinople,
October 9th, 1877,

My dear Lucas,

I arrived here all right on Saturday, after a very good voyage, and am glad to say that the people at the Seraskierate have ordered me to the front at once, and I am leaving for Plevna on Thursday morning next. I have received a great deal of kindness from everybody here. I was dining last night with old Dr. Dickson, the Embassy Physician, and a great friend of Owen Rees. I met the *Daily Telegraph* correspondent, Gay; he is a very nice clever fellow, and has just returned from Plevna, which he says is not at all a bad sort of place, but that there is only one English doctor there, and an awful lot of work to be done; so I am rather looking forward to some surgery and to carrying the standard of old Guy's, though, I fear, in a very unworthy manner, into the plains of Bulgaria. I must say I am very favorably impressed with the Turks, and I hope and believe they will win. They seem full of energy and apparently have plenty of troops yet, and I do not think they are so very short of money, as they have voluntarily offered to advance me a month's pay. I thought of you all on the 1st, and hope you had a pleasant dinner; I much wish I could have been there. I had very pleasant companions,—a Queen's Messenger, to whom I had introductions, and a correspondent of *Vanity Fair*; so we had rather a good time, going ashore at Naples and Athens for a few hours. I will write again, if I can, from the front, but the communications are rather uncertain just now, and if you do not hear anything of me for months, do not imagine I am necessarily rubbed out, for I think I shall take a good deal of killing.

Yours ever,

To R. Clement Lucas, Esq. JOHN GILL.

GUY'S 1873 CLUB.

The third annual dinner took place at the St. James's Restaurant, on October 16th. Mr. H. Davy, the President for the year, in the chair, and was efficiently supported by the Vice-President, Mr. Liddell, and the Honorary Secretary, Mr. W. D. Stamp. After dinner numerous toasts were proposed, "The Club," "The Staff," and "Success to Guy's," meeting with enthusiastic reception. Songs followed, alternations of eloquence and melody bringing a most successful and enjoyable meeting to a close. It being decided that it was advisable to alter the committee, to make it representative of the three years 1873, 1874, 1875, which form the club, a general meeting was held for this purpose on Thursday, the 18th. At this, which was the largest general meeting yet held, the following gentlemen were unanimously elected:—President, A. E. Maylard, Esq.; Honorary Secretary, W. D. Stamp, Esq. Committee, Messrs. G. J. Uhthoff, W. Brockliss, L. W. Reynolds, A. Howell, A. Scott, G. Willett.

GUY'S HOSPITAL GAZETTE, *NOVEMBER*, 1877.

THE choice of a hospital, one of the first questions to be determined by the medical student, must to a large extent depend—apart from the minor considerations of locality and convenience—on the facilities it offers to the average student of acquiring the practical part of his professional knowledge; the theoretical part—much the easier—can be got up from books in his room at home.

Among the many good medical schools of the Metropolis, Guy's has always held a front rank place for clinical training,—a fact owing not more to the indefatigable zeal of the teachers, than to the value of some of our higher appointments, especially those known as the dresserships and clinical assistantships. The distribution of these two valuable appointments is managed in such manner that all those who have done their earlier work with a fair amount of ability and energy, may reasonably expect to obtain one or both of them; for they differ in this respect from the appointments of house-surgeon or house-physician, which are only accessible to the *élite* of the hospital, and it is this fact of their being held by so large a number of men which renders it especially important that they should not be permitted to lose in value or prestige by any preventable cause.

That this has, however, been the case is beyond question. The recent enactment, which forbids the clinical-assistant or the dresser to prescribe for his patients, has made a lamentable difference in the value of just those appointments whose prestige is, perhaps, more necessary to that of the school than that of all the rest put together. The post of clinical-assistant is now but little more valued than that of ward-clerk; indeed, some men prefer the latter, inasmuch as it gives more beds; and the dresser, who, during his take-in week, has, otherwise, an almost unlimited responsibility, is not allowed to prescribe a simple mixture. It is true the law-givers have come to this safe decision at the instance of the dispensers, who have had now and then to make up a bottle of medicine twice over, and mention has been made of the expense of certain drugs alleged to be wasted by inefficient prescribing. But many of the dressers and nearly all of the clinical-assistants are qualified men, and know how to prescribe as well as their seniors in practice; that, in a few cases, their prescriptions are faulty is hardly the best possible reason for diminishing their chances of learning to improve them.

We are confident that many members of our staff are ready to endorse our opinion, that a rule which bears so hardly is a mistake in policy, which even our grand old *alma mater* cannot afford to make. The liberality which has this Session created two magnificent scholarships—albeit something of the latest—deserves a reward, which should not be frustrated by an ill-advised and mischievous decision.

THE CONVERSAZIONE.

Perfection, so they say, is never to be attained without the aid of the "fair sex;" and, hence, it was to be expected that this year our Conversazione should be even more successful than the one which preceded it. A Mysogynist no doubt would remark that, although they relieved the monotonous appearance of an innumerable collection of black coats, they in no way relieved the "awful squash" which occurs when a thousand persons are invited to occupy space just sufficient for five hundred. Still, we would have to admit that this was the fault of the entertainers; and, since doctors are supposed to know the advantages of fresh air and sufficient cubic space, we hope that next year more room will be found.

Thanks to the able management of the authorities, a collection of the most varied and interesting objects was provided for inspection. The ladies all crowded round the splendid suite of diamonds from the Cape (Mr. F. Flower), doubtless thinking that they would be far better exhibited on their own necks than they were on the table. The cross and necklace were especially fine, the diamonds in the centre of the latter being very large. One only wondered at the smallness of the value of the set, since £12,000 is a very low price for such a collection.

Of the scientific instruments, Gray's Telephone (Messrs. Gray and Ormiston) attracted by far the largest amount of attention. The fact that questions were answered through it by a man many hundred feet away from the place, made every one anxious to hear the small squeaky voice in which the answers were made, and we should imagine that the unfortunate man at the other end of the instrument was somewhat fatigued by the end of the evening. The questions and answers we heard were of a far less amorous kind than those asked at the late meeting of the British Association, where the philosophers seemed bent on demonstrating that the instrument had been invented as a medium of communication between two lovesick parted mortals. Doubtless the idea was a good one, as it would afford an example of "Thy voice is near me in my dreams," although the Telephone's voice is more like that of an "old hag with a cold" than of anyone else.

The wonders produced by electricity were also shown by numerous and varied instruments. The "vacuum tubes" were remarkably pretty this year; the electro-plating apparatus was very interesting; while Mr. Ladd's powerful machine

demonstrated to what perfection electrical machines have lately been brought.

Microscopes with specimens were placed here, there, and everywhere. Those exhibited by Mr. J. Swift were especially to be commended; while Mr. Pillischer's New International Microscope, and Mr. Baker's New Medical Microscope, are very good specimens of English workmanship.

The "pharmaceutical specimens" (Mr. Martindale), and the "modes of preparing pharmaceutical substances" (Mr. Collier), reminded us so much of the Vivâ Voce at Burlington Gardens that we fled in trepidation, lest we should be asked some question about the long forgotten articles.

The "dark room" experiments were good, and many more people would have visited them had not the crowd to get there been so great. Many, too, haunted the room where Messrs. James and Shaw demonstrated the use of the ophthalmoscope to everyones satisfaction but that of the patients.

We noticed a constant relay of batchelors around the knitting machine (Union Manufacturing Company). Since Dr. Sayre's visit to this hospital everyone is trying his plan of treatment, and it was interesting to see a machine which will knit several of his skin-fitting vests in one evening. This interest was increased by the fact that the same machine will knit a pair of socks in less than an hour. We can fancy many a confirmed batchelor knitting a vest for a patient, and then emulating an old fishwoman by working off a pair of socks; and we strongly recommend the machine to such people.

The photographs of the staff and views of the hospital (Mr. Medland, High Street, Borough) attracted much notice. Many an old and present student likes to know where to get photographs of his old teachers, and the photographs are on the whole particularly good. We hope that the one or two members of the staff, whose photographs were conspicuous by their absence, will soon enable Mr. Medland to make good all deficiences.

Amongst the numerous articles of Vertu lent by the staff and students, a series of Minton's tiles were much admired. They formed part of a collection of objects from China, India, &c., sent by Mr. J. Poland, and were beautifully painted with English flowers and fruit; whilst a model in Japanese Military Costume, lent by the same gentleman, attracted universal attention. Of great interest also were some specimens of torpedo and deep sea cables submerged two years on the coast of Brazil. They were lent by Mr. H. J. Moxon, and the foundering of ship which laid them led to the loss of the steamship La Plata in 1874.

We did not get near enough to hear the Treasurer's speeches when the prizes were distributed, although we could hear the applause with which the prize-men for the year were greeted.

But, after all, the chief charm of the Conversazione was the meeting of old acquaintances and the renewing of old friendships which took place. Old practitioners met old fellow-students, and new men gained some idea of their future teachers and associates.

The success of this year's Conversazione was great, and we have but one suggestion to make. If it is not possible to find more room for these occasions, we strongly recommend the authorities to use Messrs. Verity's hydrostatic ventilating apparatus, the admirable qualities of which were so well shown during the evening.

Physical Society.

The first meeting of the Society was held on Saturday, October 6th, the Honorary President, Dr. Wilks, in the chair.

The minutes of the last meeting were read and confirmed.

Dr. Wilks began by commenting upon the great good that was to be derived from belonging to one of the oldest medical societies in London, and said that to belong to the Physical Society was a part of our education, and that it was a duty we owed to ourselves, and that we should not be slow to avail ourselves of it. Belonging to a debating society gave men an opportunity of criticising what they had heard in the wards. He himself, and he was quite sure his colleagues also, did not like students to take all they said for granted; he liked them to examine for themselves, and ask the reason why he made such statements. He formed estimates of men as they went round the wards with him, according to the way they received what he said. He arranged them in classes. He was sorry to say he had known men, when round with him, ask no questions as to the why and wherefore, but go up to the bedcard and take down in a note book the disease written thereon, and underneath that any prescription he may have ordered. Such men he held in very low estimation, and thought that when doing this they had an eye to a few half-crowns in the future.

He remarked also on the good feeling and relationship that existed between the staff and the students of the hospital. This, he said, was due to their both aiming at truth, and in their endeavours to arrive at it they learnt from one another. He had several times had his statements doubted and criticised by the veriest tyro in medicine, and in consequence was obliged, after reflection, to alter a long-held opinion.

Whilst alluding to the greater charm surgery had to the student than medicine, he said "he is attracted by what is evident to the senses, and more especially by what is seen by the eye than heard by the ear, according to the old Horatian lines—I would not have troubled you with the very hackneyed quotation, could I not at the same time offer my own very free translation of it—

> "Segnius irritant aminos demissa per aurem,
> Quam quæ sunt oculis subjecta fidelibus, et quæ
> Ipse sibi tradit spectator."
>
> "Less keenly do the stethoscopic sounds
> Excite the student's tardy ear,
> Than knife and wounds and blood in surgeon's rounds,
> Which plain before his eyes appear."

He finally urged upon all Guy's men that it was a duty they owed to themselves and to their future patients to belong to the Physical Society. That the evening should be spent in discussing, with their fellow-student, difficulties that had arisen in the wards and elsewhere.

Mr. J. Talbot Brett then proposed, and Mr. A. Scott seconded, a vote of thanks to Dr. Taylor, on his resigning the post of Secretary, for the interest he had shown in the society, and the kind way in which he had performed the duties of Secretary during the last few years.

Dr. TAYLOR replied in a few words.

The Chairman the called upon Mr. G. MACKERN to read his paper, of which the following is an abstract:—

The physiology of the blood was briefly described, and an endeavour made to connect a few of its morbid conditions with variations in its physiological characters. The relation between the food ingested and the composition of the blood was shown in the case of *scurvy*, which was described as a progressive anæmia, attended with a great impairment of nutrition, and with a tendency to hæmorrhages; the hæmorrhages are the result of blood stasis, which is due to the morbid state of the blood. The rational method of treating this disease by a vegetable diet, which contains the needed phosphates and carbonates, was then pointed out. In *rickets* there is a great waste of calcium phosphates, so important at the period of active growth; and the treatment to restore the condition of the blood is good milk, which contains 2-4 parts of phosphate in 1,000, cod-liver oil, and careful hygiene. The principal organic group of blood is that of the proteids, or albuminoids: and, after discussing the law of Andral and Garasset "that the diminution in the amount of albumen in the serum is exactly proportional to the quantity contained in the urine," the pathology of Bright's disease was referred to. The increasing poverty of the blood, and the presence of urea and other urinary products, may seem to explain the extreme anæmia found with the large white kidney. The general anasarca was referred to the very watery condition of the blood in Bright's disease, as proved by Frerichs.

The variations in quantity of fibrin were next considered; Andral asserts "that every acute imflammation is attended with an increase of fibrin in the blood."

An account of the formation of blood was then given; it is probable that wherever adenoid tissue is found, there leucocytes are manufactured, and so the blood is renewed.

Finally, the pathology of anæmia was fully gone into: it was divided into (1) acute, and (2) chronic, and chlorosis.

Acute anæmia occurs after sudden and severe losses of blood. The symptoms in acute anæmia are due to (1) diminution of the whole mass of the blood; (2) reduction in number of red corpuscles and albumen; (3) reduction of blood pressure. The bloodvessels become positively narrower; very soon, however, there is increased flow of lymph with its corpuscles into the vessels, so that a relative excess of leucocytes is frequently observed after hæmorrhages; the temperature goes down 2-3 degrees, but soon returns to the normal; with diminished blood there is of course diminished tissue-metamorphosis and oxidation, consequently the fat of food is deposited in greater quantity in the body. The heart muscle shares in the anæmia also. An explanation was then given of the anæmic bruit.

Chronic Anæmia is of three kinds (1) that arising from direct or indirect losses of blood or other fluids; (2) that arising from deficiency of food, so-called "inanition anæmia;" (3) that of unknown causation, chlorosis and morbus Addisonii. The symptoms may resemble those of acute anæmia in a modified way, but more often there is a special poverty in red corpuscles and albumen, leading to œdema and anasarca, which complications are absent in acute anæmia.

Leucocythæmia or *Leukæmia.*—Characterised by a vast increase in number of leucocytes, with a simultaneous decrease in the number of red ones. Its pathology was discussed, and Virchow's classification into lymphatic and splenic leucocythæmia was regarded as rather artificial, after Cornil and Raurier. This disease is not a true anæmia.

Chlorosis.—In this disease Quincke has described (1) diminution of number of red corpuscles; (2) marked decrease in quantity of hæmoglotin, in one case reduced to one-third; (3) no alteration in leucocytes, albumen, or fibrin.

Pernicious or *Idiopathic Anæmia.*—Disease first described by Addison. After death, there is general fatty degeneration, especially marked in liver and heart. The appearance of the blood in this disease is very peculiar, and a full account of the examination of one case is given in the *Lancet* of May 5th, 1877. This disease, said Mr. MACKERN, was the best example he could give of a severe disease associated with well-marked visible changes in the structural relations of the blood.

Mr. DAVY, in opening the debate, said he could not agree with Mr. MACKERN that Rickets was due to a deficient supply of lime salts in the blood, since these were found in excess in the urine of the patients. He believed it due to a disease of the ossifying cells of the periosteum. He believed, too, that in Bright's disease, the dropsy had an irritative origin. With regard to idiopathic anæmia, Dr. Wilks spoke of it as being characterised by general fatty degeneration. He (the speaker) had found in one case of the disease a lesion of the liver, which seemed to point to a fatty degeneration of the organ, and he believed that idiopathic differed from other anæmia, when a change in so important an organ as the liver made the case incurable.

Mr. WHITE detailed minutely the latest theories as to the coagulation of the blood.

Mr. DOWNES criticised Mr. MACKERN'S views as to the pathology of anæmia.

The Chairman then called upon Mr. MACKERN to reply.

Mr. DAVY proposed, and Mr. SHAW seconded, a vote of thanks to the Treasurer for his presence that evening.

The Treasurer replied saying that he felt great interest in the Society, especially after what he had heard from Dr. WILKS, and that he was able to leave a wiser man thereby.

After a vote of thanks to the reader of the paper, and to Dr. WILKS for his kindness in taking the chair, the meeting adjourned.

Meeting October 20th.

MR. R. A. BIRDWOOD IN THE CHAIR.

The minutes of the last meeting having been read and confirmed, the Chairman called upon Mr. DARLEY

HARTLEY to read his paper on "Thoracic Aneurisms," of which the following is an abstract:—

Thoracic aneurism is a suitable subject for an early meeting as exemplifying to junior men the methods of medical diagnosis.

The pathology of the lesions causing it is interesting. The most common is the atheromatous, which consists of an active cell growth assuming two forms—gelatinous and semicartilaginous—according to its acuteness, and consequently undergoing a fatty, caseous, and calcaseous degeneration. It is in the cell-growth-stage that aneurism usually occurs. Primary fatty degeneration and simple atrophy (usually senile) are other lesions.

The causation of these lesions and of consequent aneurismal dilatation.—Statistics show that it is essentially a disease of middle life, and much more common in men than women. Atheroma is associated with gout, rheumatism, alcoholism, and various forms of renal mischief. Syphilis another cause. Army statistics quoted. Athletic exercises and laborious occupations. Special liability of soldiers: also of blacksmiths, bargemen, coalheavers, &c. Comparative immunity of sailors. Reasons for this special liability. Traumatic injuries an occasional cause.

Localisation of aneurism. Statistics. Course an aneurism may take, anatomical changes and consequent symptoms.—Pressure upon respiratory organs, causing pulmonary gangrene; dyspnœa; dulness on percussion; absence of breath sounds, &c. May be confounded with phthisis; case in point. May involve recurrent laryngeal nerve. Spasmodic, wheezing dyspnœa; stadrilosis voice, perhaps aphonia; phrenic nerve, and paralysis of diaphragm. Intercostal nerves, and brachial plexus, and intense pain. Sympathetic nerve, blush, and dilated pupil. May compress right auricle or superior cava, and congestion of upper half of body result; or, if innominate be involved alone, this will be unilateral: cases adduced. Pulmonary artery, cyanosis, and dropsy may displace heart downwards or forwards, communicating impulse; case given. May cause aortic insufficiency; case described. Effects of aneurism in various situations upon pulse. Pressure upon œsophagus, and dysphagia gradually coming on. Erosion of vertebra by an aneurism, and consequent characteristic pain, often only symptom; case described. Physical signs of aneurisms—thrills, dulness, bruits. impulse. Situation of these. Explanation of the bruits. One may get physical signs of aortic disease. Treatment unsatisfactory. Rest, morphia, aconite, belladonna, acetate of lead, tannin, iodide of potassium, Valsalva's and Tufnell's methods, galvano-puncture, introduction of wire or horsehair.

The modes of death in aneurism.

Mr. MACKERN opened the debate.

Mr. ELLIOT asked Mr. HARTLEY whether there was any localised pain in one of the cases which was mentioned, and whether it was possible that a bruit could be heard one day and not the next. He related a case of thoracic aneurism in which the removal in the course of some time of 130 ounces of blood was beneficial.

Mr. CAMPBELL believed that aneurism was especially prevalent amongst soldiers on account of the amount of alcohol which they consumed.

Mr. MORRISON thought that blood-letting did no good in thoracic aneurism, as it irritated the heart, making it beat quicker, and though the amount of fibrin in the blood was increased in quantity it was deteriorated, not forming so firm a clot. He mentioned that sometimes the pupil is contracted, instead of dilated, in cases of aneurism where the tumour is very large.

Mr. WHITE said that the ligature and pressure had been applied to the aorta with good result in cases of thoracic aneurism. He stated that the ascending part of the arch of the aorta was most frequently affected, as the blood issuing from the heart impinged against it with full force.

Mr. RUSSELL, in a clever and witty speech, criticised Mr. HARTLEY's paper in detail. He thought the paper reliable, but obscure in some particulars, and destitute of the dangerous originality which distinguished Mr. HARTLEY's last paper. He thought that the title of the paper included more than thoracic aneurism, for example, cardiac aneurism or aneurism about the sinuses of Valsalva. He considered that calcareous and fatty atheroma and inflammatory mollities tended in very different degrees to bring about aneurism. He believed that mechanical strain is the chief cause of aneurism, and noticed that patients whose hearts beat fully, as in phthisis, rarely have aneurism. In a great number of cases of aneurism it seemed impossible to get any history of syphilis, but rheumatic fever was a more frequent predisposing cause. He believed that 43, and not 35, was the average age to which persons with aneurism attained, He thought that loss of breath was the first symptom complained of in cases of aneurism. The most frequent cause of death is rupture of the aneurism. Tracheotomy, he said, had been proved of no use whatever in the dyspnœa due to aneurism.

Mr. BRETT mentioned that aneurism was much more frequent in men than women; out of 500 collected cases only one-eighth were women. He thought that the starvation treatment did no good, as it tended to prevent the coagulable lymph being thrown out.

Mr. PILKINGTON thought that soldiers frequently had aneurism owing to their carrying heavy, bodily-fitting knapsacks and to their frequently having syphilis.

Mr. PALMER narrated a case of a syphilitic prostitute, which he had seen P.M., where there was a very large aneurism of the aorta.

Mr. DAVY maintained that it was chiefly army surgeons who believed in syphilis being a cause of aneurism, whereas at the Lock Hospitals there were very few cases of aneurism. He thought that patients suffering with aneurism complained of pain before complaining of breathlessness.

Mr. DOWNES believed that syphilis lead to aneurism by the endoarteritis which it set up.

After a vote of thanks to Mr. HARTLEY for his paper, the meeting adjourned.

Football News.

GUY'S HOSPITAL FOOTBALL CLUB.

Season 1877-78. President, J. N. C. Davies-Colley, Esq., M.S., F.R.C.S. Vice-President, R. Clement Lucas, M.S., F.R.C.S. Captain, A. Scott. Deputy-Captain, A. H. Jackson. Hon. Secretaries, F. J. Elliot and T. A. I. Howell.

A general meeting of the Club was held on Thursday, October 11th, Mr. F. J. Elliot in the chair. Mr. T. A. I. Howell, Hon. Sec., was called upon to render an account of the financial state of the Club. He then stated that he had suc-

ceeded Mr. P. D. Wallis, in October, 1876, who left the Club £8 7s. 4d. in debt. The Club is now about £16 in arrears. Then followed a statement of the expenses incurred by the Club.

Cr.	£	s.	d.
For Subscriptions Jerseys and stockings	29	3	6
Balance due to Treasurer...	16	5	2
	£45	8	8

Dr.	£	s.	d.
Last year's debts ...	8	7	4
Man putting up goal posts, &c., ...	3	0	0
Travelling expenses of four G. H. F. C. men to Liverpool & Leeds to play for the U. H. F. C.	6	0	0
Lawrence, for Jerseys...	5	8	0
New Football	0	10	6
Subscription to U.H.F.C.	1	1	0
Markham, for 2 Caps ...	1	9	3
Stationery, Stamps, Telegrams, &c. ...	1	0	7
Ash & Flint, for printing	1	9	6
Slade's bill at "Princess of Wales."	14	0	6
Lillywhite, for new goal posts	3	2	0
	£45	8	8

Mr. Howell tendered his resignation but was re-elected.

Mr. Elliot being elected as joint secretary.

Mr. Elliot proposed, and Mr. Scott seconded, that two of the members of the Staff should be asked to act as President and vice-President.

Mr. Scott was then elected Captain of the first fifteen, with Mr. A. H. Jackson as Deputy-Captain.

The meeting was well attended, there being between seventy or eighty men present.

Subsequently Messrs, Scott, Jackson, Howell, and Elliot, appointed Mr. Pierson as Captain of the second fifteen.

OPENING MATCH, October 6th.

Played at Blackheath. The men showed up well and were able to play seventeen a side; from the form shown we may look forward to a successful season.

GUYS *v.* CLEVEDON.

Played at Blackheath, October 13th. The home team winning by one goal, dropped by Grouce and one touch down to one touch down. *Backs.*—A. Penny, F. J. Elliot. *Three-quarter back.*—Maylard. *Half-back.*—Veitch, Dixon. *Forwards.*—A. Scott (Captain), Wilkinson, Lister, Roberts, Trott, Flannagan, Grouce, Bertie Whyte, Trevor, Mead.

GUYS *v.* BLACKHEATH.

Played at Blackheath, October 20th. L. Stokes, who is a host in himself, obtained five touch downs, three were converted into goals; Shaw obtained another touch down, which was turned into a goal. Guy's forwards played remarkably well and showed at every scrimmage their superiority.

Guy's. *Backs.*—Penny, Elliot. *Three-quarter back.*—J. Buno. *Half-back*—Veitch, Dixon. *Forwards.*—A. Scott (Captain), Wilkinson, Lister, Cox, Rees, Flanagan, Whyte, Jeys. Three men short.

Blackheath. *Backs.*—A. W. Pearson, A. Chamier. *Three-quarter-back.*—L. Stokes. *Half-back.*—W. D. Bovill, H. R. Shaw. *Forwards.*—W. C. Rawlingson, Fraser, G. W. Burton, C. A. Cattley, H. N. Smith, G. Spurling, T. J. Bailie, and A. Hill.

UNITED HOSPITAL FOOTBALL CLUB.

A meeting was held at King's College Hospital, on October 19th; Guy's being represented by Messrs. Scott and Elliott.

It was then arranged that the following Guy's men should play in the match against Blackheath on October 31st. *Half-back.*—A. H. Jackson. *Forwards.*—Veitch and Scott. Penny being first substitute for back.

VIVISECTION.

The following was sent anonymously to one of our late house-surgeons; he, thinking it worthy of publication, has handed it over to us. It is evidently written by one of the gentler sex.

VIVISECTORS, PAUSE AND BEWARE!

For *you* may be reserved an eternity of the same tortures and agonies which you have, with the nature of fiends, inflicted on gentle innocent helpless creatures; for *you* will be reserved the blackness of darkness for ever, into which you will enter from your conscience-stricken death-beds, fearful with remorse and horror! *You* showed no mercy, can you expect any? DOWN, DOWN to the DEMONS you resemble; a just RETRIBUTION.

We have received subscriptions of 5/- from the following gentlemen:—

Gibson, J. H.	Davies, H. A.
Longman, G. P.	Woolley, G.
Smallpiece, H.	Leeks, E.
Fitzgerald, E. L.	Newnham, W. H.
Shillitoe, H. S.	Edensor, A.
Price, G. A.	Edmunds, D. T.
Pitt, G. N.	Payne, F. C.
De Winten, A.	Jones, E. L.
Wells, H. S.	Denby, W.
Jackson, M.	Hart, W. H.
Scott, A.	Scott, R. J.
Blatherwick, H.	Day, T. M.
Eastes, F.	Powell, L.
Brogden, R. W.	Atkinson, T. R.
Steadman. C. R.	Skelton, W.
Elliott, E.	Downes, T. L.
Southerst, M.	Growse, W.
Downes, G. L.	Wells, A. G.
Pollard, G. S.	Unicume, F.
Ensor, H. C.	Martin, J. P.
Booth, E. H.	Hall, W. H.
Griffin, J. M.	Morse, J. H.
Woodruff, J. W.	Blomfield, J.
Swindlehurst, J. M.	Fotherby, H. A.
Osborne, H. R.	Howell, J. B.
Howard, W.	Stephens, L.
Warner, P.	Whittaker, S.

NOTES OF THE MONTH.

The dissecting-room was this year unusually full, there being over a dozen subjects in the room by the first. They have been collecting in the vaults since the end of the last winter session, and have kept remarkably well. They are still being brought up as fast as they can be prepared. There ought to be very little difficulty this year in getting two parts done before Christmas.

The new building is fast approaching completion. One can now judge somewhat of the appearance of the various class rooms. They are all lofty and capacious. The rooms on the ground floor are a little dark, but those upstairs, intended for the microscope classes, are admirably lighted, and are a great improvement on the old practical physiology room.

L.R.C.P., October. At the late examination the following gentlemen obtained the Licence:—Messrs. F. C. Colley and J. A. Masters.

An account of the Conversazione, held on October 1st, will be found in another part of our columns. It is needless to say that it was a great success, the admission of ladies having not a little to do with it.

EXPULSIONS.—We have been given to understand that two students, whose conduct was not considered satisfactory by the Staff, have received notice from the Treasurer that their privileges have been withdrawn and that they will not again be admitted within the precincts of the hospital, it being the intention of the Treasurer and Staff to maintain the gentlemanly tone which has always characterised the students of this hospital.

It occasionally happens that, shortly after an operation for strabismus, the eyeball becomes unusually full and prominent. Should this occur, hæmorrhage beneath the subconjunctival fascia may be suspected. Firm pressure with a bandage will stop further bleeding. In rare cases the eyeball becomes protruded, and sloughing of cornea takes place.

All Guy's men will regret to hear that Dr. ALFRED S. TAYLOR has resigned the office of Lecturer on Medical Jurisprudence in this hospital. This appointment was conferred on him by the Treasurer and Governors of the hospital in March, 1831. He has, therefore, held it continuously for the long period of forty-six years. Dr. TAYLOR held also the office of Lecturer on Chemistry from 1832 to 1870, a period of thirty-eight years. Dr. TAYLOR retires full of vigour and rich in a matured experience, by which, on critical occasions, the profession and the public are, we apprehend, still likely to benefit when his critical and well balanced judgment is imperatively called for by adequate authority.—*Brit. Med. Journal.*

The precocity of infants, especially in America, is often truly remarkable. A correspondent of the *Manchester Examiner* asks for information respecting a child which he states, according to a small paragraph which appeared in the papers about twelve months ago, lived after its birth in America for only half an hour, during which time it remarked that "there would be terrible bloodshed in Europe during 1877." Some of the leading papers in England "reviled the idea of a child living half an hour and speaking as it did do;" but the writer thinks the affair is worthy of notice, and would be glad to hear further particulars with regard to the communication made by the child during the brief period of its existence. The inquiry will perhaps lead to some more minute details of the statement referred to, which, it is only due to the child to admit, proved to be only too accurate. A story, however, hardly less interesting is related by a Chicago paper of a newly born infant, who the other day created a profound sensation in the nursery by asking immediately after it had been placed in its bassinet to be supplied with a couple of cigars, a brandy-smash, and the latest edition of the *New York Herald*, its request being couched in such strong language that the milk in its bottle was turned sour and its nurse was sent into "one horse convulsions."—*Pall Mall Gazette.*

DEATH.—Benjamin Thomas, F.R.C.S., Llanelly, Born April 13th, 1814, died April 2nd, 1877.

Mr. A. K. Morgan, at a late examination at the Apothecaries' Hall, obtained the Gold Medal in Materia Medica.

OPEN SCHOLARSHIPS.—The examiners for the above have recommended the following:—

Arts.—Mr. W. Hamilton Hart.
(Proxime Accessit.—Mr. C. Haig Brown.)
Science.—Mr. E. L. Adeney.

Owing to the large entry this year, the physiology lectures have been so crowded that it has been necessary to open the gallery to the students.

We understand that Lord Lawrence has resigned the office of President of the Hospital, on account of advancing years and increasing blindness, and that Lord Cardwell has been appointed president in his place, Lord Cottesloe having declined the honour because of his age.

We are enabled to announce an unusually good entry this year, 108 men have entered as full students, 7 have taken out courses of special classes. With so many men in a "year" there will be naturally a good deal of competition, when the time arrives, for the higher appointments. As these appointments are given according to the respective merits of the candidates, and work in the dissecting-room is taken into account as well as work in the wards, it behoves all men, who desire to make the best use of their time here, to settle down at once to earnest and steady work,

ON DUTY FOR NOVEMBER.

Senior House-Physicians:—Messrs. A. G. Lacy and W. P. Reynolds.
Junior House-Physician:—Mr. C. W. Lacy.
Senior House-Surgeon:—Mr. J. Mackern.
Junior House-Surgeon:—Mr. A. G. Barrs.
Senior in Charity:—Mr. J. T. Gardner.
Junior in Charity:—Mr. C. F. Pickering,

DRESSERS FOR THE WEEK.

October 31st.—Mr. Wainewright (Mr. Forster).
November 7th.—Mr. Berry (Mr. Bryant).
„ 14th.—Mr. Giles (Mr. Durham).
„ 21st.—Mr. Beale (Mr. Howse.)
„ 28th.—Mr. Hearnden (Mr. Forster).

LINES BY A LUNATIC M.D.

Oh! fair are the halls where stern *Peritonitis*
Makes love to Miss *Asthma*, and courts the *Catarrh*;
Where the bright *Influenza* is wooed by *Iritis*,
And *Psora* joins *Measles* in "Beautiful Star."

Oh! bright gleam the eyes of that fair *Erythema*,
And lightly *Pneumonia* whirls round in the dance;
Pleuritis is madly in love with *Œdema*,
And *Herpes* courts *Cholera* with amorous glance.

And old Mrs. *Scabies* told Mr. *Phlebitis*
She'd brought *Melanosis* at last to the point;
You know he's six thousand a year; (*Laryngitis*
Will find that his nose is a bit out of joint.)

Long, long I shall dream of that pet *Scarlatina*,
She gave me a rash from her rose at the ball.
Oh! that thrice happy night when Miss *Gutta Serena*
Kissed Captain *Psoriasis* out in the hall.

Adieu! sweet *Chorea!* Farewell! *Carcinoma!*
Hysteria my heart with emotion doth swell:
That heart *Anasarca* is thine. *Atheroma*
And bonny *Neuralgia* a lasting farewell.

Written by H. Saville Clarke, Esq., and published in a collection of "Comic Poets of the Nineteenth Century," arranged by W. D. Adams. Published by George Routledge and Sons.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

EXAMINATION FOR THE LICENCE (Second part, or pass.)
October, 1877.

MEDICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF MEDICINE.

Including the principles of Public Health.

1. Describe the sounds heard in Mitral Regurgitation. Mention the usual cause and progress of the lesion, and give a short account of its consequences.
2. What are the distinctive characters of the eruption in Measles, Scarlet Fever, and Small Pox?
3. Give the tests for the presence of Albumen, Sugar, Phosphates, Sulphates, and Chlorides in the urine.
4. Describe the minute structure of the Lung. How is it changed in the exudation stage of Acute Pneumonia? What would be your treatment of an uncomplicated case of this disease?
5. What is the condition of the Kidney in acute Bright's Disease? Give a sketch of its progress and treatment.
6. In an epidemic of Small Pox what measures would you suggest in order to arrest its spread?

MIDWIFERY AND THE DISEASES OF WOMEN.

1. Give the causes of Amenorrhœa; with indications as regards the appropriate treatment of each variety.
2. Why is delivery in face presentation more difficult than in vertex presentation? When is it necessary to interfere? and what means would you employ?
3. A woman three months pregnant, having had many abortions, sends for you in consequence of an attack of Hæmorrhage. How would you supervise such a case, and state what are its liabilities.
4. Give an account of the signs and symptoms of obstructed labour. Describe the treatment appropriate in various cases.
5. Give an outline of the pathology and diagnosis of Cancer of the Uterus.
6. How would you distinguish between, (*a*) pregnancy at eight months, (*b*) a large ovarian tumour, and (*c*) considerable distention of the abdomen with ascitic fluid.

MATERIA MEDICA, AND CHEMISTRY IN ITS APPLICATIONS TO PATHOLOGY, PHARMACY, AND TOXICOLOGY.

1. Enumerate the different Purgatives. How do they act? What are the indications for their use? In what doses would you give them?
2. What are the chief Anthelmintic Medicines? How do they act? How would you administer them?
3. State the derivation, the chief therapeutical uses, and the dose of each of the substances named below; enumerate the pharmaceutical preparations of each, and give the strength and dose (if any) of each preparation:—

Belladonna (leaves and root).
Morphia (acetate and hydrochlorate).
Iodine.
Iodide of Potassium.
Bael fruit.
Colchicum (corm and seeds).

4. How are the pharmacopœial Hydrocyanic and Phosphoric Acids prepared? Mention the dose of each, and the preparations (if any).
5. How much Potassium Chlorate is required for the preparation of 1,800 cubic inches of Oxygen Gas, on the assumption that a cubic inch of the gas weighs 0·34 grain? K=39·1. Cl=35·5. O=16·0.
6. If you had to search for Arsenic or Antimony in a Stomach, and only one or the other was contained, would in be possible to look for one and not find the other.
7. Explain the chemical constitution of the following substances:—Stearic Acid, Glycerine, and Stearin. How may Stearic Acid be prepared from Stearin?
8. Give two methods of making Urea, artificially, and from the urine. State the composition of Urea, and the various modes of detection.

STATISTICAL REPORT OF LYING-IN CHARITY FOR SEPTEMBER, 1877.

Number of women attended				207
Recovered		207		
Died		0		
		207		
Single Births				206
Dual				1
				207
Women attended in 1st confinement				31
" " 2nd "				30
" " 3rd "				27
" " 4th "				28
" " 5th "				20
" " 6th "				18
" " 7th "				12
" " 8th "				13
" " 9th "				8
" " 10th "				7
" " 11th "				5
" " 12th "				6
" " 13th "				2
				207
Children at full time.				
Males alive		109		
Males dead		3		208
Females alive		93		
Females dead		3		
Total number of children				208
Alive		202		208
Dead		6		
Presentations.				
Vertex			202	
Breech			2	
Footling			1	
Face			1	
Occipito posterior			2	
			208	
Operations.				
Low Forceps		2		
High Forceps		2		
		4		
Externs attended.				
Mr. John Cock				37
Mr. G. H. Russell				48
Mr. E. Fillding				49
Mr. E. B. Granger				46
Mr. W. F. Hearnden				27
				208

H. W. EWEN,
Obstetric Resident.

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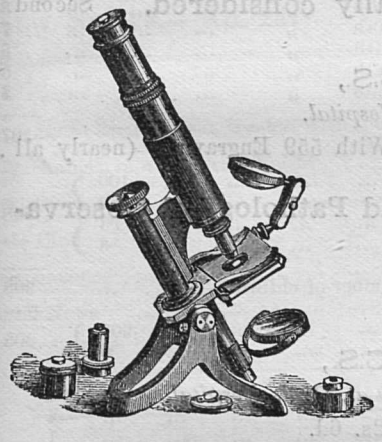

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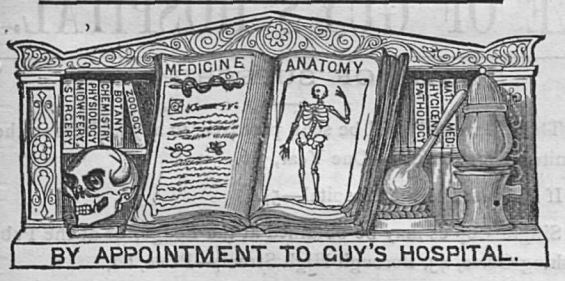

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CASE OF ACUTE RHEUMATISM TREATED WITH COLD BATH.

Communicated by Mr. T. S. Sheldon.

The following case of acute rheumatism presents points of interest, besides illustrating very well the value of cold bathing in the pyrexia of that disease.

Thomas Cook, æt. 29, gasfitter, was admitted into John ward on October 6th, 1877. He then reported that he enjoyed good health, until a few months ago he took to drinking hard, losing, in consequence, his appetite, and suffering from dyspepsia and malaise. A fortnight ago he had an attack of tonsillitis.

His present illness, which he attributes to changes of temperature incurred in his employment, commenced on October 1st with a feeling of stiffness about the shoulders and a sense of illness which compelled him to give up work. On October 2nd his knees and ankles were swollen and painful; his left wrist became affected on October 5th, and on the following morning he was sent to the hospital.

On admission.—He is a well proportioned, dark complexioned man, very pale, and sweating profusely; odour characteristically sour. Both knees and ankles are swollen and slightly erythematous, but are not very painful; both wrists are swollen and painful, as also is the joint between the 1st and 2nd phalanx of the index finger of each hand. There is no severe pain anywhere. Bowels confined since the 1st. Heart is healthy, except weakness of first sound. Lungs healthy. Urine loaded with lithates; contains a little albumen. Tongue furred and rather dry. Temperature, 102°5; Pulse, 136, very compressible. All his movements are very tremulous and his manner is confused.

October 6th & 7th.—He appeared to improve, the swelling and pain in joints subsiding.

October 8th.—Delirious all last night. This morning he is confused, and cannot answer questions readily. Pulse is very weak, so wine was ordered. At 12 midnight his temperature was 105°, so he was placed in a cold bath, the subsequent fall was as below:—

12.9—103°5
12.18—98°2. He was then taken out.
12.25—100°3.

The temperature was observed at intervals until the following morning:—

1.0—101°4 3.30—100°3 6—104° 10.30—101°4
2.30—103° 5—103° 7—103°

On the 12th it is recorded that "an abundant crop of sudamina has come out on the chest." He complains of pains in the elbows and wrists. Tongue is red and very dry. Muscles are tremulous. His delirium, which comes on at night, is of delirium-tremens type. A small quantity of albumen in the urine.

October 13th & 14th.—Delirious all the day, as well as in the evening. Tongue is taking on a typhoid appearance. At 10.30 p.m. on the 14th, his temperature was 106°; there was occasional low muttering delirium; he was unable to answer questions, or put out his tongue when asked, as he could do previously when delirious. He was at once bathed, and the following are the temperatures as observed until 1.30 a.m. on 15th:—

10.30—106°—Bath, temperature of water 104°
10.45—104° 11.8—99°
10.53—103° 11.13—97°
10.58—101° temperature of water was 88° taken out
11.3—99°8 1.30—99°

The effect of the bath was very remarkable: when first put in he was delirious and quite unconscious. After a few minutes' immersion the delirium abated with the temperature, he was able to answer questions, and expressed the comfort which the bath afforded him.

From October 15th to October 20th he remained slightly delirious during the day, more so during the night, the temperature meanwhile sinking gradually from 104° to 100°. The tremor was very evident all this time, and the tongue still maintained its dry, brown appearance.

On October 22nd temperature sank to normal, the delirium had ceased, and, physically and mentally, he was much better. From that time he has gone on uninterruptedly well.

The points of interest in the case stated briefly are

1.—The very valuable therapeutic effect of the cold bath. The wording of the report does not adequately express either the alarming condition of the man on the second occasion, or the speedy and wonderful change for the better during the bathing.

2.—The severe febrile state which not only persisted, but became aggravated, after the disappearance of joint affection. October 12th was the last occasion on which it was found necessary to record any pain in the joints, and the swelling had then disappeared.

3.—It may be a question whether the character of the delirium, the tremors, and perhaps, in part, the fever, do not point to a concurrent attack of delirium tremens. Or, it may be one of those cases, in which, a drunkard becoming the subject of an affection involving delirium, the latter assumes the character of delirium tremens. In either case, the cerebral aspect of the affection is worthy of consideration.

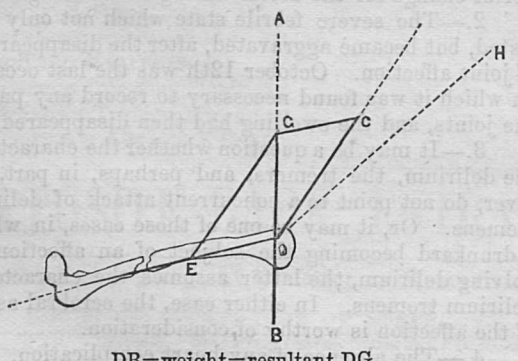
4.—The absence of any heart complication.

The only treatment adopted was a purge on admission. Subsequently he had stimulants in small quantities.

THE MECHANISM OF A HODGEN'S SPLINT.

Possibly any one seeing a fractured shaft of the femur put up in the Hodgen method for the first time would be inclined to doubt the security of the limb, since all rigid apparatus is absent. The first point to note in the application of this method is the securing

of the foot to the end of the wire splint, if such we may call it, whereby the latter and the leg from the knee downwards becomes for all practical purposes one piece in relation to any force acting at all towards the foot of the bed and pulling from any point along the leg. The body can only be regarded as a fixture for the man with his head and shoulders on the pillow, and cannot in any way be a suspended weight. The hip joint is the fixed point, and the axis of the thigh the line of the counter extension. The active force is the weight of the limb from the fracture downwards, with a portion of the thigh above resting on the cradle. If we suppose, for sake of simplicity, that the cord attached near the knee supports the whole weight, as would be the case if it were applied over the centre of gravity and the other cord dispensed with, then the state of things could be easily expressed in the accompanying statical problem. Let GD be the weight acting in the vertical direction, DC and DE the directions of the cord and of the counter extension respectively. It is seen at once that the downward tendency is distributed between DC and DE, that the latter receives a share not so much less than the active force, and therefore the counter extension resists, *i.e.*, is equal to, a force rather less than the suspended weight of the limb. The more the angle EDC is opened the greater is the extension, and vice versa. In the case of the second cord, the forces admit of exactly the same mode of statement, only a larger share of strain is thrown upon it in relation to the counter extension than in the case of the first, because of its less obliquity.



DB=weight=resultant DG.

A practical conclusion from this is that excessive extension can be readily reduced after the limb has been put up by lowering the point of suspension of tht upper pulley, thus producing a greater obliquity in the cords as in the dotted line DH.

J. M. HOBSON.

MENTAL DISEASE?—II.

In last month's number of the *Gazette* a slight attempt was made to trace out some of the similarities existing between the alleged phenomena of witchcraft and of spiritualism, in the hope that the facts might be of some use to persons investigating spiritualism from a scientific point of view; and it was suggested that as the two classes of phenomena grew up under somewhat similar external circumstances, and showed such a curious family likeness, it was possible that both were due to a mental condition not yet thoroughly understood.

In *Frazer's Magazine* for that month, Dr. Carpenter commences an article on Spiritualism with these words:—"Since the publication in *Frazer* of the two lectures on Mesmerism, Spiritualism, &c., which I delivered at the London Institution near the close of last year, I have learned much more than I had previously known both of the extent of what I hold to be a most mischievous *Epidemic Delusion comparable to the witchcraft epidemic of the seventeenth century, and of the very general existence of a peculiar state of mind* which as much predisposes to attacks of spiritualism as did the almost universal belief in Biblical authority for the existence of witches determine the witch-persecutions in Puritan New England."

The article, unfortunately does not deal with the mental part of the question. It is chiefly a consideration of the amount of evidence that should be demanded in proof of any alleged spiritual phenomenon; and an attempt to show that the principal English supporters of the doctrine, Messrs. Crookes and Wallace, have been content with far less than the minimum than should be insisted on. But the paragraph quoted gives reason for the hope that in the forthcoming work on the subject which Dr. Carpenter promises that point will at last be examined by one so fitted to undertake the task. Dr. Carpenter's position is that the phenomena now attributed to spiritualism are the result of pure trickery; but from the present stand-point, which is:—"Is it possible that an abnormal pre-disposition to believe in certain supernatural phenomena may exist at certain epochs, and under certain conditions?"—this is of no importance; and the object of this second article is to show that counterparts exist in the history of witchcraft of two clases of supposed phenomena to which Dr. Carpenter makes special reference: namely, the de-materialization of objects incapable of volition, and the materialization of spirits.

The modern phenomena belonging to the former class are of this nature. A medium in a circle of spiritualists, all possibility of jugglery being supposed to be excluded, will produce any flowers, plants, or fishes, that may be asked for, into the circle, frequently with the natural moisture upon them to bear evidence to the good faith of the obtainer of these spiritual favours. The witches of the seventeenth century were not in the habit of exhibiting their powers in a crowded drawing-room to an elegant audience: their æsthetic feelings effected them less than their physical necessities; and consequently oatmeal and cod offered greater attrac-

tions than lilies of the valley and lobsters. But they were able to obtain similar results with different materials. Isabel Gowdie, who was tried for witchcraft in 1662,* confessed that when the witches wanted to obtain the produce of any corn field, they took three straws, and plaited them, saying:—

"We cutt this corne in our Lord the Devellis nam,
"And we sall haiv the fruit of it ham."

And when the corn was ripe, it was conveyed into their barns without more trouble on their part.

In a similar manner when they wanted fish, they went down to the sea-shore when a fishing-boat was returning home; said an equally absurd rhyme: "and with that we haiv the fruit of the heall† fishes in the boat, and the fishes that the fishermen thamselves will haiv, will be bot froath."

The second point of similarity is the belief in the materialization of spirits. The ordinary belief concerning spirits is that they are purely immaterial, but at the present time spiritualists, like their predecessors, hold that they retain their original corporal form without being subject to the laws that regulate the outward material world. Consequently, when spirits appear at séances, they are easily to be recognised by their friends, if not from actual inspection, at any rate from the description furnished by the clearer-sighted medium. In the same way Horatio and Marcellus were able to furnish Hamlet with an accurate description of the appearance of the ghost of Claudius, even down to the condition of his complexion, and the colour of his beard. And that this was an accurate representation of the belief of the times and not merely a dramatist's license may be proved by the following quotation. It is taken from the trial of Bessie Dunlop for witchcraft, in 1576, one of the earliest Scotch trials on record. She was asked from whence she obtained her supernatural information, and she answered from one Thom Reid, who had recently died at Pinkie. She was asked to describe him; and she she said: "he was ane honest wele elderlie man, gray bairdit, and had ane gray coitt with Lumbart slevis of the auld fassoun; ane pair of gray brekis, and quhite schankis, gartanit abone the kne; ane blak bonet on his heid, cloise behind and plane before, with silkin laissis drawn through the lippis thairof."

It seems doubtful whether any modern spirit can materialise as successfully as Thom Reid seems to have done, nor do they seem to be so useful in their operations; for Thom used to give Bessie herbs and medicine that cured many diseases. After his interviews, he would disappear through a hole in the wall, too small for any earthly man to pass through.

These are only indications of a parallelism that could be worked out with much greater effect if greater space could be afforded them. It was intended to confine those indications within the limits of our former article; but the subsequent appearance of Dr. Carpenter's Essay suggested the propriety of showing that the similarities were not by any means confined within the limits before marked out, but that, in fact, given any striking phenomenon of modern spiritualism, its counterpart may probably be to be found in mediæval witchcraft.

*Pitcairn's Criminal Trials of Scotland. Vol. III., p. 614.
†Whole.

GUY'S HOSPITAL BICYCLE CLUB.

A General Meeting was held on Thursday, November 22nd, to consider the advisability of forming a Bicycle Club.

Mr. F. J. Elliot was voted to the Chair.

It was unanimously agreed to form a Club.

Dr. Moxon has kindly consented to act as President.

Mr. Morse was elected Captain and Mr. F. J. Elliot as Treasurer and Secretary.

The following officers were elected.

Committee. — Messrs. H. Boswell, H. Clowes, J. W. Hodgson, J. Kidd.

The following Rules and Regulations were agreed to.

Rules.—1. That the Club be named the Guy's Hospital Bicycle Club, and be strictly confined to Guy's men.

2. That the Club colours be Orange and Blue.

3. That the Club uniform be dark blue serge jacket, single-breasted with four buttons; knee breeches of same material and dark blue stockings, and that members be particularly requested to wear the same at Club meets.

4. That the affairs of the Club be managed by the Committee, Captain, and Secretary, who shall be elected at the Annual General Meeting in January, with power to add to their number. Three to form a quorum.

5. That the Club consist of Active Members and Honorary Members. The Active Members to pay an entrance fee of One Guinea, and an Annual Subscription of Five Shillings, payable in advance on the 1st of February. Honorary Members to pay a Subscription of Ten Shillings.

6. That any gentleman wishing to join the Club may be proposed and seconded by members, and that his name be given to the Secretary, who will call a Meeting of the Committee, at which he will be balloted for.

7. That all elections be by ballot of the Committee, one black ball in three to exclude.

8. That notice be sent to each member on his election, with a copy of the Rules and Regulations, and a request for payment of his entrance fee and subscription. This payment to be held as a submission to the Rules and Regulations of the Club.

9. That any member failing to pay his subscription within three calendar months from the time when due, be liable to have his name erased from the list of members.

10. That any member violating the Rules or Regulations, or guilty of any misconduct, shall be expelled from the Club.

11. That a General Meeting of the Club be held the last Thursday in January in each year, to receive the Report and Statement of Accounts, and to elect Officers and Committee for the ensuing season.

12. That the Club colours or badge be not worn on Sundays.

13. That no member represent the G.H.B.C. at any race meeting without permission of the Captain.

14. Notices of runs and excursions shall be printed and sent round to all members.

Bye Laws for Club Runs.—1. Members shall wear the complete uniform of the Club under the penalty of 2s. 6d.

2. *The Captain to have command of the road, and that no* member shall pass the Captain on the road.

3. The Rule of the road shall be observed.

4. All members when wearing the Club uniform shall carry a bell, under the penalty of 2s. 6d.

Head-Quarters of Club, "The Plough," Clapham.

N.B.—Gentlemen desirous of joining the Club are requested to give in their names to the Secretary as soon as possible, in order that the requisite number of silver badges may be ready by February 1st, 1878, which will be presented by the Club to each Active Member.

List of Members.

Adenny, E. L.	Edwards, S.
Bolton, A.	Fitzgerald, E. L. G.
Bayes, F. T.	Harrison, J.
Clowes, H.	Hodgson, J. W.
Cortis, H. L.	Kidd, J.
Crosse, W. H.	Norley, E. J.
Downs, G. L.	Spong, J. F.
Elliot, F. J.	Sells, H. D.

Correspondence.

[We are not responsible for the opinions expressed by our Correspondents.]

To the Editor of the "Guy's Hospital Gazette."

Sir,

Can you, or one of your readers, inform me whether any notice has been taken of the memorial to the Treasurer with respect to the new regulations affecting the Dressers and Clinical Assistants. Those regulations so closely affected the value of the appointments that the presentation of the memorial was a duty which the petitioners owed to their successors; and backed as the memorial was by the sympathy of the staff and the active support of some of its members it was to be expected that it would meet with some amount of attention. Up to the present I have heard nothing more about it, but hope you will be able to enlighten me on the subject.

I am, Yours truly,

One of the Petitioners.

[We can give no information on this subject beyond the fact that when the memorial was sent to the Treasurer he signified his intention of inquiring into the matter before giving any reply. We believe that nothing further has been heard on the subject.] Ed. G. H. G.

Football News.

A large meeting of the members of the Football Club was held on Wednesday, November 14th. Mr. Pinching was called to the chair, and the chief business of the meeting was to appoint a new Captain and Secretary owing to the resignation of Messrs. Scott and Howell. The chief reason for their resignations was the difficulty of getting good teams together, many of the Guy's men preferring to play for other clubs. The culminating point appears to have been that one of the best players played for another club, after scratching his name off the list of players in a Guy's match for the same day on the plea of being unwell, and in this way caused the Guy's match to be put off. Probably that gentleman now regrets an action which has led to the resignations which have occurred. At the same time we cannot help thinking that too much has been made of a small matter; and we regret that Mr. Scott was unable to withdraw his resignation when the meeting unanimously re-elected him Captain. The Guy's Club must indeed be in a bad way when the refusal of one of its members to play leads to the putting off of a match; and if this is to occur often Guy's will soon cease to be the champion hospital in football. At present, if only the members of the Club will pull together with that *esprit de corps* which has up to the present been one of their chief characteristics, there is every reason to hope that the challenge cup will remain ours for several years to come. If, on the other hand, its members refuse to play in the matches which have been arranged for them it will soon lose all its old *prestige*. The essence of success in football is that the players should all pull together, and this can only be acquired by constant practice. Hence, unless those who are going to play for the challenge cup sink minor differences in the one aim to gain it, we may as well decide at once to give up our present position to some other hospital. In the end, Mr. H. Veitch was elected Captain, and we hope that the Club will now have no more difficulty in getting her members to play for the hospital.

MATCHES PLAYED BY FIRST FIFTEEN.

GUY'S HOSPITAL *v.* CLAPHAM ROVERS.

This Match was played on Blackheath, on Saturday, Oct. 22nd, and ended in favour of the Rovers, by two tries and several touchdowns to nothing. The Match was played in a perfect downpour of rain, which effectually prevented any brilliant play on either side. The Rovers winning the toss elected to play down the hill. Veitch started the ball for Guy's, and the ball being badly returned the first scrimmage was formed in neutral territory. For some time the game was pretty even, the forwards on either side working well, and Jackson for Guy's making several neat runs. But after about a quarter of an hour's play the ball was worked down to the Guy's 15, chiefly by the good play of the Rovers' ¼ backs, and the Guy's had soon to touch down in self defence, which measure they had quickly again to resort to. Shortly before half time Bryden for the Rovers obtained the ball and ran in, but the try, though an easy one, was a failure. Up till half time nothing more of importance occurred. After half time the game was more even, till Shaw, by a good run, obtained a second try for the Rovers. The Place kick, though a very difficult one, was nearly successful; Birkett sending the ball just wide of the Post. Immediately after starting the ball Guy's had again to touch down in self defence. After this matters went on more hopefully for the hospital, as their forwards, by some very good play, aided materially by Jackson behind, gradually fired the ball down to the Rovers' territory, and when no side was called, the game was close on the touch line of the Rovers. For the Rovers, Birkett and Shaw were most conspicuous. For Guy's, Jackson behind, and Lister forward, played very well. Both sides played a man short.

Guys.—*Backs*, Penny, Growse; *Three-quarter-back*, Fasken; *half-backs*, Jackson, Long; *forwards*, Veitch, Lister, Wilkinson, Scott, Mead, Jeyes, Trott, Flanagan, Ireon.

GUY'S *v.* WALTHAMSTOW.

The above match was played at Walthamstow, on Saturday, November 17th, and was the first time that we have played against Walthamstow. Guy's winning the toss, Echalaz kicked off, and the ball not being returned by our backs, a scrimmage was formed close to our goal line. By united forward play and short runs by our half-backs, we gradually removed the ball away, but all to no purpose, as Lloyd getting the ball after a little loose scrimmage play, ran in for Walthamstow, from which try Echalaz kicked a goal. Veitch kicked off, but the ball being well returned, a scrimmage ensued in the centre of the ground, but one of the Walthamstow half-backs getting hold of it ran in a second time and another goal resulted. A third goal was got before half time by Walthamstow. On changing ends Veitch kicked off, and our forwards following up well caused a scrimmage to be formed in their territory, and working together the ball was worked into touch in goal. This was the only point scored by Guy's, while Walthamstow obtained 5 more tries, chiefly owing to our want of good men behind. Two goals were kicked from these tries, and thus Walthamstow won by 5 goals and 3 tries to 1 touch in goal.

For Guy's, Jackson played well behind the scrimmage, while the forwards one and all played well, and were always well on the ball. Our team was as follows :—

Q. R. Veitch, *Captain*; A. H. Jackson, *three-quarter-back*; Cuff, Dixon, *half-backs*; E. Penny, Fasken, *backs*; A. Scott, J. H. Lister, J. Boswell, R. Cox, Mead, A. Jeyes, Growse, Green, F. S. Pilkington.

UNITED HOSPITALS *v.* OXFORD UNIVERSITY.

This match which was played on the Parks, Oxford, resulted in a victory for the "United." The following Guy's men played, L. Stokes, *three-quarter-back*; A. W. Pearson, *back*; A. H. Jackson, *half-back*; and Q. R. Veitch, *forward*. It is pleasing to know that our representatives greatly distinguished themselves; Stokes getting two tries and kicking two goals, Jackson three tries, whilst Veitch was within an ace of obtaining a try, he being collared only a yard from the "Varsity" goal line, whilst Pearson tackled well allowing no one to pass him.

GUYS *v.* SYDENHAM HILL.

This match was played at Sydenham Hill, on Saturday, November 24th, and resulted in a draw. Veitch lost the toss so we had to play for the first half against the wind and hill. Guy's followed up well after the kick off, and the first scrimmage was formed in our opponents' ground. Guy's gradually worked the ball towards their goal line, and soon a touch-down was recorded in favour of Guy's. One of the Sydenham men then kicked out from the 25 yard flag, but the ball being well returned, a few more scrimmages ended in another touch-down for Guy's. Again Guy's forced them to touch down, but could not obtain a try, Jackson and Cuff making great efforts to run in. Soon after half time was called. After half time the ball was kept in neutral ground, but the drops of the Sydenham men caused us to touch down in self defence three times. Soon after there was a scrimmage and cry of "man down," but the Sydenham half-backs disregarding this, ran in and claimed a try, but the ball had to be brought back, and nothing further was scored till time was called. The heavy nature of the ground, which was not improved by the rain, made the game very slow. The forwards again played well, especially Veitch, Scott, and Lister, while behind Jackson and Cuff did good service. Our team was as follows :—

Q. R. Veitch, *Captain*; A. Scott, J. H. Lister, T. Wilkinson, Mead, A. Jeyes, R. Cox, Green, Symonds, Arnott, *forwards*; Jackson, Cuff, *half-backs*; Lawson, *three-quarter-back*; E. Penny, B. Scott, *backs*.

MATCHES PLAYED BY SECOND FIFTEEN.

GUY'S HOSPITAL *v.* BARTHOLOMEW'S HOSPITAL.

This Match was played at Battersea Park, November 3rd. St. Bartholomew's won the toss, and took the kick off; unfortunately Guy's backs failed to return the kick, consequently the first scrimmage was dangerously near our goal, nor was the ball removed from this unpleasant locality until Guy's had been compelled to touch down three times. After the third touch down, however, Fasken made a splendid drop out, which was briskly followed up by Guy's men, who in their turn kept the ball close to the Bartholomew's goal till half time. Guy's now kicked off, but were driven back and made to touch down twice more; after this the Bartholomew's men were driven down to their goal by Guy's forwards, and made to touch down themselves. Fasken and Dixon distinguished themselves throughout the game by their prompt play, and constant runs. The Bartholomew's men passed the ball splendidly, their two backs playing together quite prettily.

St. Bartholomew's.—Barling, *Captain*; Adams, Faddy, Richardson, Gill, Thomas, Lavehlan, Little, Heath, Shaw, *forwards*; Sales and Stephen, *quarter-backs*; Bowlly, *three-quarter-backs*; Treherne and Stevenson, *backs*.

Guy's.—Pierson, *Captain*; Bishop, Pilkington F. S., Cox, Wilkinson, Flanagan, Harper, Lowdell, and J. L. Jones, *forwards*; Dixon and Long, *quarter-backs*; Fasken, *three-quarter-back*; B. Scott and Edwards, *backs*.

GUYS *v.* THE GNATS.

This return match was played on our ground at Blackheath, November 25th; the weather could not well have been worse, an icy cold rain with a driving east wind. The Gnats having won the toss, chose the easterly goal, giving us the kick off. On account of the wind, Guy's did not get much of a start, and the first scrimmage was considerably on the western side of the half-way flag. The Gnat's made good use of the wind, and kicked whenever there was an opportunity. There was now some sharp loose scrimmaging near our goal line, and Guy's were forced to touch down. The drop out after this was a failure, and the Gnats soon brought it down to our goal line again, and the Guy's back with difficulty touched it down. The ball was again brought out and well followed up, and carried on by Jones, however the ball was soon brought back again by the Gnats after this brief reverse, and soon one of their forwards kicked a goal out of a loose scrimmage. Guy's having kicked off again, kept the ball in the middle of the ground till near half time, when Fraser having had the ball passed to him, ran right in behind our goal and obtained a try, which he himself soon converted into a goal. Soon after this Guy's had to touch down again, and half-time was called. The latter half of the game was somewhat monotous, although Guy's forwards played admirably, nothing more was scored on either side till time was called.

Fraser, Johnstone. Long, King and A. Lovey, were very active among the Gnats; whilst for Guy's Flanagan, Jones, Whyte, Harper, and Fasken did great service.

Gnats.—Fraser, *Captain*; Long & Johnstone, *quarter-backs*; Scobie, *half-back*; F. Lovey, *back*; Daly, Pattison, Comins, Oldfield, Wolf, Da Costa, King, A. Lovey, and Angell, *forwards*.

Guy's.—Pierson, *Captain*; and Edwards, *back*; Fasken and Dixon, *three-quarter-backs*; Harper and Cudaham, *quarter-back*; Flanagan, Jones, Whyte, Creey, Hawkesworth, Kendall, Trevor, Lowdell, and Logan, *forwards*.

You never get inflammation near a muscle without its being paralized.

Irregular paralysis which you cannot focus is generally due to Syphilis.

GUY'S HOSPITAL GAZETTE, *DECEMBER*, 1877.

WE do not think that the "New Rules relating to the Dressers and Clinical Assistants," to which a correspondent calls attention in another column, have, as yet, met with the general attention that they deserve.

For the last fourteen years prescriptions signed by the dressers and clinical assistants have been dispensed without further question. In the case of the Clinicals this has been their only advantage over the medical ward clerks whose greater number of beds more than compensates for the formers supposed right of the choice of cases; a right, however, which is now invariably broken through, when, from any cause, it seems convenient to do so. It has never been pretended that the care of the hospital patients rested with the dressers and clinicals; nor have they ever attempted to claim any such privilege. But both surgeons and physicians have always given them a certain amount of license and this has been gratefully accepted whenever it has been conceded. Occasions arise in which the immediate alteration or exhibition of a medicine is necessary. A new patient is often admitted at least two days before the staff's next visit; or, occasionally a prescription so obviously disagrees with the patient that some alteration is necessary. In such cases the dressers and clinicals have been accustomed to prescribe, and if to these we add surgical cases, which are, or have been in the hospital, in which the salts of iron, mercury, iodine, or cod liver oil, are called for, we have included all the cases in which prescribing was ever attempted. The good feeling and respect which has always existed between the staff and the senior students has been amply sufficient to prevent the latter from attempting to infringe on the formers duties; and, at any rate, for the last fourteen years no difficulty has arisen. Suddenly everything is changed. A dresser writes on the board for some caustic and learns for the first time from the nurse, who goes to the dispensary to fetch it, that nothing is to be dispensed for a dresser without the counter-signature of the house-surgeon; while the clinicals learn in much the same way that their old privilege has been put a stop to. Neither the surgeons nor the physicians know anything as to the matter, and the new regulations have actually to be learnt by the staff and students from the nurses and subordinates in the dispensary. It is said that these regulations are made for two objects: *First*, in order to save the waste of medicine which is caused by the countermanding of the prescriptions by the staff. *Second*, to lessen the dispenser's work. Now, in the first place, it is not true that the prescriptions were often countermanded. The dressers and clinicals are the picked men of the hospitals, who have been studying the profession at least three years. They only prescribed when medicine was absolutely necessary and as a matter of fact it was most exceptional for their prescriptions to be countermanded. Nor do we believe that this would occur less frequently if all the irregular prescribing was done by the house-surgeons and house-physicians, who are, in many cases, only a few months their seniors; and whose other duties are too arduous to allow them to have anything like the knowledge of the cases which is possessed by the dresser and clinicals. As a matter of fact, by far the largest amount of countermanding of prescriptions takes place in those medical wards in which the house-physicians alone ever venture to prescribe. Nor will the actual amount of prescribing be lessened, for there is no one on the staff who would refuse to try any system of treatment which has proved useful, and in fact, the students are always encouraged to make suggestions. The regulations then will not, and cannot, effect any perceptible amount of economy; nor will they lessen the dispenser's work as much as some good rules preventing prescriptions from being sent to the dispensary at irregular and inconvenient times. But if so little good to the hospital can be expected from these regulations, how do they effect the dressers and clinicals? Not only do they take *all* direct responsibility off his hands and so entirely do away with one of the most essential parts of a senior student's training; but they prevent his gaining a practical knowledge of prescribing; and, finally, they place him in an utterly false position.

Every one will allow that the art of prescribing is a most difficult one to acquire; and so much is this the case that it is notorious that men going up for even so high an examination as the second M.B. (Lond.) are often incompetent to write an ordinary prescription. Students then value every chance which they get of prescribing for a disease; and the amount of prescribing done by the dressers, and especially the clinicals, gave them a general idea of most of the best preparations in a practical way which they never forgot.

But, after all, the most annoying part of these Regulations is that they place the senior students in a disagreeable and false position. They are unable to prescribe drugs which their juniors (assistant-surgeon's-dressers and dressers in the surgery) prescribe freely. If an old patient, who has been formerly under their care in the hospital, comes into the ward to see them requiring cod-liver oil, or some preparations of iron, a full dresser, or a clinical, cannot, as such, now prescribe it; although, if he sign himself dresser in the surgery (an appointment held by men two or three years his junior) there would be no difficulty in getting the medicine. Such a state of things shews that the New Regulations are altogether misunderstood by the authorities. Economy and decrease of work for the dispensers will be obtained by a proper arrangement of the surgical out-patient department; and the prevention of prescribing for medical cases by the assistant-surgeon dressers. It will not be effected by the New Regulations, which are only harrassing and annoying to the senior students on whose gratuitous work the efficiency of the hospital depends.

We must point out, too, that the mode of enforcing these Regulations was as unhappy and undignified as could well be imagined. That the staff and students are to learn new rules, affecting their old established customs from the nurses and dispensers is truly astounding. We cannot but think it would be better for the authorities to find some other way of communication, and we are sure that many mistakes and much ill-feeling would have been prevented if this had been done.

We hardly hope that these regulations will be now altered since the treasurer has taken no notice of the memorial which has been sent him. But we do hope that in future no regulations affecting the appointments will be made until the staff have been thoroughly consulted. Guy's has always been distinguished by the practical nature of her clinical teaching; her great men owe their reputation to her matchless system of appointments, and if she is to retain her foremost position in this respect it will not be by an abolition of the old established privileges of her senior students.

Physical Society.

The third meeting of the Physical Society was held on November 2rd. Mr. F. C. Coley in the chair. Mr. J. Poland read a paper on "Secondary Hæmorrhage and the application of Torsion," of which the following is an extract:—

A description of Secondary Hæmorrhage, especially as distinguished from the forms of recurrent hæmorrhage, was first given, together with its principal clinical symptoms; as, drowsiness, coldness, tossing of arms, waxy appearance of skin, syncope, &c.

The local causes of secondary hæmorrhage were then detailed, and with them the different modes of arresting hæmorrhage from an artery, old silk ligature, acupressure, torsion, carbolized catgut ligature, cautery, styphics, &c. The manner in which the artery was occluded and the different ways in each case in which hæmorrhage may recur. In torsion, hæmorrhage only occurs when, as the result of a constitutional condition, the artery sloughs and is not due to any local cause; there being no ulcerative process as in the case of ligature. The same sloughing occurs, of course, after the use of the ligature, but it is more prone to lead to hæmorrhage after ligature, since there is the presence of the ligature to ulcerate and weaken the artery, but not of necessity in the case of the carbolized catgut ligature. All the cases of secondary hæmorrhage that had occurred at the Hospital for the last ten years were then gone through. They shewed the very small proportion of cases after torsion as compared with the ligature, gut ligature, and acupressure. In per centage, less than half of the silk ligature and about half of the gut ligature, 3·66 per cent. after torsion, 7·81 per cent. after old silk ligature, 32·63 per cent. after acupressure, and 6·43 per cent. after the gut ligature.

The constitutional causes of recurrent hæmorrhage, including sloughy condition of the wound, were de-

tailed: Pyrexia, Bright's disease, &c.

Treatment very briefly noticed, but especially Mr. Cripp's advice about carefully adjusted pressure persistently applied.

In conclusion, a few words on the application of torsion, Nature's method of arresting hæmorrhage, as exemplified in a lacerated artery.

Very much the same kind of thing might be observed in animals, when they rub or scratch thin wounds, to produce friction and, sometimes, laceration of the mouth of the bleeding vessels.

Torsion was artificially divided, for the purpose of description, into five stages :—

1.—Seizure of the artery.

2.—Twisting of vessel on itself.

3.—Continued twisting and breaking of the middle and inner coats.

5.—The external coat retains its twisted position and supports the incurved coats. The support is permanent, and not for a certain period only, as in ligature.

The paper was illustrated by statistics.

Mr. HARTLEY thought that Mr. POLAND, who for a long time had sat at the feet of of the Gamaliel of Torsion at Guy's, should have given a more systematic classification of Hæmorrhage. He thought too he talked too much of the ligature in the past tense. There was one form of secondary hæmorrhage, which he would call Tertiary, and occurred after syncope caused by hæmorrhage. The agent in cutting through the inner coats is the constriction caused by the ligature. He thought sloughing of the end of the artery occurred more often than Mr. POLAND made out. He suggested that acupressure was more successful at Aberdeen because patients there are more robust than London men. He alluded to Mr. BRYANT'S theory of Esmarch's bandage, that more blood is really lost after all. He suggested that the catgut ligature was only used temporarily.

Mr. WOOD thought Mr. POLAND forgot all operations except amputation, and that he only mentioned hæmorrhage after amputations, and not after ligature. He thought he should have gone more fully into the constitutional causes of secondary hæmorrhage. Mr. HEATH suggests that if it is thought likely that secondary hæmorrhage might occur (as in cases of Bright's disease) a mark should be made over the line of the main artery, so that even a nurse might compress the artery without loss of blood.

Mr. MANSELL thought that the word temporary was not a good one for catgut ligature, because so many surgeons use it for large arteries.

Mr. WHITE said that if antiseptic surgery was applied it would do away with the liability to secondary hæmorrhage; because antiseptics checked ulceration and suppuration, and hence sloughing of the ends of the arteries. In the treatment of the hæmorrhagic diathesis he should try arnica and glaubers salts, as recommended by a German surgeon. He thought that catgut was not used as a temporary ligature.

Mr. MAYLARD did not see how Mr. POLAND could come to any conclusion from his statistics, because Holmes thinks the chief cause of secondary hæmorrhage is atheroma, and these cases only are tied at Guy's. He thought the ligature acts as a foreign body, and so may cause ulceration of artery even in antiseptic cases.

Mr. RUSSELL thought that ligature of an artery close to a collateral branch did not tend to secondary hæmorrhage, and that as in other parts a clot would be formed. He thought that in such a disease as Bright's disease, the arteries being rotten would give way. Deaths from other causes are sometimes due to the weakening effects of hæmorrhage, which renders the patient more liable to pyæmia. He thought Mr. POLAND'S statistics were too valuable to be lost, and should be published. The catgut ligature was not temporary.

Mr. MORRISON asked for an explanation of Guthrie's assertion that hæmorrhage takes place from the distal extremity of an artery, he did not think the action of gravitation would account for it. The effects of catgut ligature are permanent: the ligature itself is but temporary, as it is melted and absorbed, but its effects are lasting and permanent.

The Chairman then called upon Mr. POLAND to reply.

After a vote of thanks to the reader of the paper the meeting adjourned.

The fourth meeting of the Physical Society was held on Saturday, November 17th. Mr. Henry Davy in the chair. The treasurer honoured the Society with his presence.

Mr. C. H. Downes read a paper on "Diseases of the Spleen," of which the following is an extract :—

The more obscure the physiological functions of organs are, the more difficult becomes the diagnosis of their diseased conditions, because with them there is no evident use with which to connect the symptoms.

This is probably the reason why in the spleen and other similar viscera, so many contrary opinions concerning pathology are held.

The writer proposed to discuss four kinds of splenic disease in addition to simple enlargement of the organ during ague. It was pointed out that simple hypertrophy was probably not caused as suggested by Sir Thomas Watson, merely by blood pressure on a distensible viscus, but that it was due to a low form of inflammation set up by the action of malarious or otherwise abnormally affected blood, and this was more probable from the fact of the intimate association and probable functional association of the blood with the delicate tissue of the organ.

A case of enlarged spleen occurring in a man who had died during the relapsing stage of relapsing fever was advanced in support of this proposition, and it was said to be probable that a form of capillary phlebitis was present.

Dr. Frederick's theory of the action of the blood in all cases of acute infectious disease was discussed, and the usually normal size of the spleen in a series of cases of diphtheria, erysipelas, and other infectious diseases, occurring during 1876, was advanced in opposition to Dr. Frederick's statement.

Some of the physical signs of hypertrophy were detailed and the fact that in many cases of slight enlargement it is necessary to pass the fingers beneath the ribs was noted.

The proposition that hypertrophied spleen was generally preceded by evidence of some derangement of the circulatory system was supported by the fact, that, in twenty-three cases of death from secondary abscess after injury, eight had enlarged spleen, and that in thirty-eight cases of death from cholera the

spleen was increased twenty-four times, in seven the increase was eight fold. Moreover, in eleven cases of ulcerative endocarditis occurring at Guy's, in 1876, the average weight of the organ was 18 ozs., in two it was more than 20 ozs, and in three over 20 ozs. in weight.

A case of hydatid in spleen was described, that afterwards suppurated, and after death it was found to communicate with the spleen.

The pathology of splenic lardaceous disease was discussed, and it was shown that during 1875 and 1876 the spleen was very little more frequently affected than the liver and kidneys.

In considering the cause an analysis was given of twenty-two cases occurring at Guy's in 1876, and it appeared that in all but one a history of phthisis, syphilis, or some joint disease was found.

A case of Hodgson's disease associated with leucocythæmia was discussed, and it was thought to be peculiar in the rapidity with which the general system became affected after the gland swelling.

Two cases of splenic abscess were brought forward, in both of which leucocythæmia was present, and both of which had originated from a blow, it was thought that blows sufficiently severe to cause inflammation leading to abscess would rupture the organ. But it might be that a latent tendency to leucocythæmia was vivified by the irritation of the blood.

One of the cases was peculiar in that the leucocythæmia stopped when the abscess had been discharged by an incision, and many of the symptoms abated, but the abscess rapidly filled again, and finally remained as a permanent trouble which lasted until the death of the patient seven years after his first seizure, the abscess during all this time alternately discharging and healing again.

The difference in the corpuscles in leucocythæmia and leuchæmia was then discussed, and it was said that, as in no disease of the spleen, but one or two where inflammation is set up in the organ, is there any tendency to leucocythæmia, and as an increase of leucocytes may be present without any disease in the spleen, it is probable that leucocythæmia is due to some distant lesion of the organ or the analogous organs the lymphatic glands, and not to any superabundant action of their natural functions.

Mr. UHTHOFF, in opening the debate, said that Mr. Poland, who was unable to be present, had asked him to take his place. He thought that Mr. Downes might have chosen a subject less abstract and more suitable for debate in such a society as our own. Mr. Downes had spoken of a case of Hodgkin's disease in which the white cells of the blood were increased in number: such a case would be one of leucocythæmia, and not of Hodgson's disease, for the only clinical difference between the two was the presence of an increased number of leucocytes in the former disease. He objected to the expression that leucocythæmia "was a disease inherent in the blood."

He then related three cases of diseases of the spleen, each of considerable interest: and terminated his speech by asking what effect on the body generally was produced by disease of the spleen.

Mr. RUSSELL said he could not too much admire the care and thought shown in the paper, but he regretted that such care and thought had not been bestowed on a more practical subject. The diseases of the spleen had no clinical aspect. In fact, if Dr. Wilks' definition of disease as a group of symptoms constantly occurring together, were taken, then there were no diseases of the spleen. The connection between even leuchæmia and the spleen was loose, since you might have leuchæmia without splenic enlargement, splenic enlargement without leuchæmia. From a pathologicai point of view, the derangements of the spleen were, however, not uninteresting, as in it some very important pathological changes, common to it and other organs might be conveniently studied. The rest of the speech was occupied in a brief sketch of such changes, including embolisms, lardaceous disease, tubercle, &c.

Mr. W. H. WHITE thought Mr. Downes' paper very badly arranged; he read a number of cases, without stating to which disease they referred. The chemical changes in the spleen were altogether omitted. He thought Mr. Hartley wrong in attaching so much importance to the spleen as physiologically it may be excised without any ill results. He mentioned the glandular theory of disease.

Mr. MORGAN thought it very probable that the changes in the blood found in some of the diseases of the spleen and lymph glands were not due to an actual increase in the number of leucocytes, but that in these cases the development of the leucocytes was arrested and the red blood discs were not formed from them. The weakness, &c., found in many of these cases was due to the want of oxygen and he remarked that Dr. Michael Forster prescribed for them a richly albuminous diet. Mr. Downes had not mentioned the enlarged spleen found in India which was said to be benefited by the application of iodide of mercury ointment.

Mr. WOOD related particulars of a very interesting case which had been in Luke ward. Some time after undergoing an operation on the knee, the wound of which had completely healed without a bad symptom, the patient was attacked with rigors and fever and was thought to be suffering from pyæmia, It was found that his spleen was enlarged and quinine was given. A few days after the spleen went down and all his symptoms subsided. He related two cases of chronic capulitis or the spleen. These were often mistaken for dyspepsia from the pain coming on after meals. They were to be distinguished by the enlargement of the spleen, the absence of vomiting, and the presence of hiccup. If treated with arsenic, they soon got well.

Mr. H. MOXON mentioned a case of splenic enlargement following a fall across a bar which had subsided under treatment with quinine.

Mr. HARTLEY was surprised at Mr. Russell's strictures upon Mr. Downes' choice of a subject. Pathological conditions are not by any means unworthy of investigation, because clinical symptoms are not definitely connected with them. In the present imperfect state of our knowledge, such is the case in many instances, but their number is continually diminishing. It is important to bear in mind the difficulties, both clinical and pathological, attending the investigation of this organ. Clinically the indications afforded by palpitation and percussion are obscured by its mobility, the movements of the diaphragm and the posture of the patient materially affecting its position. As a matter of fact there is often the widest discrepancy between the clinical and post-mortem reports. Again, the close likeness between the normal constituents of the organ and the products of inflammation render its pathological investigation difficult. He would ask Mr. Downes if he could explain the small hard spleen which goes generally with cardiac disease. This although usual is not an invariable condition. Case adduced. The pyrexial enlargement of the organ often an indication of danger in ulcerative endocarditis.

Splenic enlargement common in domestic animals, and attended with prominent anæmic symptoms. The experiments of Jaschkorvity showed that on division of the splenic branches of the sympathetic, vascularity of the organ resulted.

A vote of thanks was then proposed to the reader of the paper, and to the treasurer for his kindness in being present, and the interest he manifests in the Society, and was unanimously carried. In replying, the treasurer dwelt on the importance of splenic disease in India, and mentioned many interesting details with regard to the way in which the natives treat their cases. One case especially was of importance in which an officer of his acquaintance was tried for murder, and only escaped on the medical evidence. He had kicked his native servant for some petty offence, and the servant, in trying to escape the kick, twisted his body, and fell down dead. The medical men certified that the death was due to ruptured spleen, and that this organ was in such a bad condition, that any exertion would have led to the man's death. The treasurer concluded by urging those students, who might be thinking of a career in India, to study especially a disease on which such important issues might turn.

EXAMINATION NEWS.

SECOND M.B. PASS EXAMINATION. LONDON UNIVERSITY.

OBSTETRIC MEDICINE.

1.—Give a detailed description of the progress of the head through the pelvic canal in normal labour in the First and Third positions of Cranial Presentation.

2.—Describe the duties of the Accoucheur from the termination of the second stage of labour till he leaves the house.

3.—What are the several indications for Podalic Version, and the methods of performing it?

4.—State what you know of Menorrhagia, its causes and treatment.

5.—How would you distinguish a large Fibroid Tumour of the uterus from other conditions occasionally mistaken for it?

6.—State what you know of Puerperal Mania, its causes, course, and management.

GENERAL PATHOLOGY, GENERAL THERAPEUTICS AND HYGIENE.

1.—What are the chief antipyretic remedies? State their relative value, the conditions under which you would have recourse to each, and the mode of their administration.

2.—In what points do the phenomena of Dying, caused respectively by disease or defective action of the lungs and heart, resemble and differ from one another? What are the chief post-mortem appearances observed under each of these conditions?

3.—What conditions are to be observed in a proper sanitary arrangement of the sewerage and water supply of a house provided with water closets (*a*) in a town, communicating with a common sewer, and (*b*) in the country, and isolated from other houses?

4.—What are the principle disinfecting agents? Describe the mode of action of each.

5.—What are the chief causes of chronic valvular disease of the heart?

6.—What are the physiological effects of the Nitrite of Amyl? In what morbid conditions is it most useful? Describe its mode of administration.

SURGERY.

1.—Sketch the various forms of mischief which may follow a severe blow on the head without fracture of the skull.

2.—Describe the symptoms and treatment of the various complications that may attend fracture of the ribs.

3.—Mention the causes of Cystitis. Describe the symptoms and pathological changes in the acute and chronic forms of the disease.

MEDICINE.

1.—What are the distinctive characters of intestinal, biliary, and nephritic colic?

2.—What is meant by the terms Bronchophony, Pectoriloquy, Ægophony, Metallic Tinkling, and Hippocratic succussion? Under what conditions are these signs severally to be heard? Explain the mechanism of each.

3.—Under what circumstances does Pericarditis occur? and what are the symtoms, the physical signs, and the treatment of the disease in its several stages?

4.—Describe the symptoms of Lead-poisoning, and their appropriate treatment.

5.—Describe the different modes of origin of Pneumothorax. Give the physical signs of this condition and the data for its diagnosis.

6.—What conditions may give rise to Spasmodic Asthma? How is this disease to be distinguished from other forms of difficult breathing? Describe its appropriate treatment.

FORENSIC MEDICINE.

1.—Define and describe the conditions and signs of Maturity, Viability, and Live Birth.

2.—What are the points to which you would direct your attention in forming an opinion as to the suicidal or homicidal character of a gunshot wound?

3.—What are the most approved methods for the Restoration of the Drowned, and what dangers are to be guarded against in attempts at resuscitation? In the case of a corpse removed from the water, what are the indications that death was the result of drowning?

4.—Give the symptoms, course and termination, post-mortem appearances, and treatment, of Poisoning by the Mineral Acids; and state how, during life, you might ascertain what acid had been administered.

5.—Describe the symtoms and post-mortem appearances resulting from a fatal dose of Tartar Emetic? How would you diagnose a case of chronic poisoning by Tartar Emetic during life?

6.—Give a short account of the chief forms of mental derangement manifested in connexion with Epilepsy.

PRESCRIPTIONS.

(To be written, with the directions for administration, in Latin without abbreviation.)

1.—Write a prescription for profuse night-sweats in Pulmonary Phthisis.

2.—Prescribe Bael Fruit for a case of Dysentery.

3.—Prescribe Copaiba for a case of Hepatic Dropsy.

4.—Prescribe Salicylate of Soda for a case of Acute Rheumatism.

5.—Prescribe for a patient with Chronic Enlargement of the Spleen due to Malaria.

6.—Write a prescription containing Chloride of Ammonium for a patient with Congestion of the Liver.

MICROSCOPE. SIX SPECIMENS.

1.—Cystine. 2.—Hydatid hooklets with crystals of triple phosphate, and calcareous particles. 3.—Oxalate of Lime crystals, various forms. 4.—Trichinæ coiled in muscle. 5.—Fatty infiltration of striped muscular fibre. 6.—Sarcinæ Ventriculi.

PATHOLOGY.

1.—Inflamed red Kidney. 2.—Colloid of omentum, mesentery and peritoneum. 3.—Large lobulated spleen with *hæmorrhagic infarts.* 4.—*Tubercle of mesentry and peritoneum* with enlarged glands. 5.—Ulcers of cæcum, probably dysenteric. 6.—Fibrinous casts of bronchial tubes.

PASS LISTS.

LONDON UNIVERSITY.

The following gentlemen passed their 2nd M.B. Examination :—

1st Division.—Messrs. P. Horrocks, C. J. Symonds.

2nd Division.—Messrs. G. H. Keyworth, L. H. Stevenson.

Subsequently the following honors were obtained—

MEDICINE. P. Horrocks the Gold Medal (getting the number of marks qualifying for the exhibition, which was gained by a St. Thomas's man.)

C. J. Symonds obtained third place.

OBSTETRIC MEDICINE. C. J. Symonds the 2nd Gold medal.

L. H. Stevenson, Honors.

P. Horrocks, Honors.

FORENSIC MEDICINE. C. J. Symonds, the 2nd Gold Medal.

L. H. Stevenson, Honors.

Mr. L. C. Woolridge obtained the B. S. degree at the last examination.

ROYAL COLLEGE OF SURGEONS.

The following gentlemen recently passed the final examination for the fellowship :—

Messrs. W. E. Paley, A. E. Amphlett, W. H. Harsant, Clarke, Elliott.

At the first Fellowship Mr. R. White passed.

The following gentlemen obtained their Diplomas at the recent examination : —

Messrs. H. L. Manby, A. S. Taylor, P. Richards, W. Lane, G. H. Parry, A. J. Johnstone.

Messrs. T. Poland, A. Birt, G. Puddicombe passed in Surgery.

A GUIDE TO THE EXAMINATIONS AT THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

FREDERICK J. GANT. BALLIÉRE & Co.

We must confess to opening any book bearing but the slightest suspicion of cram with a feeling akin to aversion, for we are fully persuaded in our own mind that a man of the most moderate abilities can, by honest work, and in the time prescribed by the examining-boards, pass his examinations with both credit to himself and advantage to his future patients. "Cram work" is not honest work, and to get through an examination with a minimum of reading is a despicable aim for a student of the healing art.

We would not have our criticism referred to the little book before us ; it only disposes of the apprehensions which were excited in us by the title of Mr. Gant's production. As a matter of fact the book is a useful (in truth a most useful) aid to students wishing to pass the College examinations in a satisfactory manner. One hears so many awful tales of the crotchets and conundrums which are then asked the unfortunate candidates, that any book which gives a true idea of the straightforwardness of the examinations is much to be commended. Mr. Gant's book undoubtedly does this, and it does more than this, for by giving the questions which have been asked it guides the student in his reading. Surgery is so wide a subject, that without some help a student may work and work, and yet be quite unfit to pass an examination in the subject generally. Mr. Gant's book shows that a moderate knowledge of the most varied kind is required; and so by preventing a student from undue concentration in one branch of the subject, aids him materially to pass in all. The Book then is a valuable guide to the examinations at the College of Surgeons, and as such we recommend it to future candidates.

APPOINTMENTS.

The following appointments were made by the Medical Council on November 27th.

Resident Obstetrics.—Messrs. Hinton, Uhthoff, G. Mackern.

Dressers.—(Mr. Cooper Forster) H. Morley. (Mr. Bryant) G. Russell. (Mr. Durham) Messrs. Stuart and Hartley. (Mr. Howse) Messrs. Keep and Stanley Taylor.

Clinical Assistants.—Messrs. Paddison, Wainewright, Beale, Green, Lowdell, Deare.

Eye Wards.—J. W. Meek.

Medical Ward Clerks.—Messrs. C. L. Jones, Deane, Baldwin, Alexander, G. H. W. Jones, C. Wood, Williamson, M. F. Cock, R. White, Bovill, Cox, Briscoe, P. Wood, T. B. Cross, Pilkington, Austen.

Assistant-Surgeon's-Dressers.—Messrs. Maylard, Morgan, Brockless. Scott, Wright, Crossley, P. P. Jones, Clowes, Fuller, Hine, Penny, Mathews, Howell, Bedford, W. H. White, Parry.

Dressers in the Surgery.—Haycroft, E. O. Stuart, Crew, Barns, Shelswell, Bishop, Whitworth, M. P. Morgan, Moore, Woolridge, Hodgson, Sturge, P. S. Pilkington, Sanders, Lewis.

Surgical Ward Clerks.—Messrs. Charles, P. S. Pilkington, Shelswell, Woolridge, Moore, E. Fielding, Morse, Thomas, S. Jago, W. Morgan, B. Scott, Atkinson, Cockell, Hodgson.

Assistant-Surgeon's Clerk.—Whitaker, Dendy, Robertson, Vernall, Gard, Jnorr, Sturge, Harper.

Obstetric Out-patients Clerks.—Messrs. Steele, Coles, Phillips, Bryden.

Aural-Surgeon's-dresser.—D. D. Malpas.

Post-mortem Clerk.—C. H. Downes.

NOTES OF THE MONTH.

A change has been introduced into the Surgical Out-patient department. Up to the present all patients who applied were attended to, the minor cases being subscribed for by the Assistant-Surgeon's-dressers, whilst all the more difficult and important cases were seen by the Surgeon. By the present arrangement a limited number of cases only will be seen. 20 cards will be given out to the graver cases who will then be prescribed for by the Surgeon; while 15 cards will be given out by each of the two dressers to the minor cases, who will afterwards be attended to by these dressers.

Two towns in the North of England are taking a lead in Sanitary Reform.

Huddersfield and Bolton have instituted a process for the registration of infectious diseases.

The Corporations of the Town Boroughs provides medical practitioners with forms for the certificate of disease, which have to be filled up and sent to them as soon as they are called to attend the case.

Should no medical man be in attendance the duty of informing the Corporation falls upon the head of the family, or the occupier or person in charge of the house in which the infectious disease occurs.

Any person offending against this enactment is liable to a penalty of five pounds.

The medical practitioners receive a fee of two shillings and sixpence for each certificate.

Our readers will be glad to learn that an endeavour is being made to train the Guy's Nurses, who up to the present time have had no regular system of instruction. Dr. Steele will give a series of lectures on ventilation and the requisites of ordinary ward work ; whilst Miss Nicholls and Mr. Collier will respectively teach the art of bandaging, and give hints

on the administration of medicines, &c. This is only part of the general change which the nursing department is at present undergoing. The nurses have for so many years been chiefly distinguished for the efficiency of their scrubbing that the alterations by which this duty has been taken off must take some time before they work well. They ought, however, to produce in the course of time an efficient staff of nurses superior to those of any other hospital.

The courses of lectures will, doubtless, be very useful, and we hope that their originator will have every success in carrying out the new improvements.

The following paragraph appeared in the last number of Hay's American Journal of Medical Sciences, at the commencement of a Review of Vol. XXII of the Guy's reports.

"This is the oldest and best of the English Hospital reports. We never take up a volume of the series without pleasant anticipations, and we never lay one down without having those anticipations realised."

The Journal in question is the leading American Medical Quarterly. Its yearly critique is of the more value, as its opinion is a perfectly unbiassed one.

The EDITOR acknowledges with thanks the receipt of the following—

Students Journal. Sanatory Record. Proceedings of the Medical Society of the county of Kings. Also communications letters, &c., from—

Messrs. J. C. Uhthoff, T. S. Sheldon, P. A. Spalding, P. Horrocks, G. Mackern, W. D. Hartley, C. T. Knox Shaw, T. Poland, A. Scott, W. H. White, F. T. Elliott, J. H. Lister, T. H. Berry, G. Downes, G. H. Russell, H. Campbell, H. L. Manby, A. Pierson, "A dresser," "Extern," J. M. Hobson.

COLLECTION OF SPECIMENS OF THE ORGANIC MATERIA MEDICAL FOR THE USE OF MEDICAL STUDENTS.—Messrs. Southall Bros. & Barclay, of Birmingham, have brought out a most useful collection of Materia Medica specimens. In a neat wooden box are contained specimens of all the leaves, roots, etc., in the British Pharmacopœia. These Specimens, of which there is a liberal quantity, are enclosed in stout envelopes with the name, natural order, character, etc., printed outside. Such a collection as this is of great value to students preparing for examinations in Materia Medica. For they are enabled to gain their knowledge from the actual substance, and thereby render much more interesting an otherwise somewhat dreary study.

TENTH EDITION.

MATERIA MEDICA EXAMINATIONS.

BRITISH PHARMACOPŒIA, 1867,

Further enlarged by additions to the B.P., &c.; and there is now included, in each case, a copy of "The Organic Materia Medica," by W. SOUTHALL, F.L.S.

The Original Collection of Specimens of the Organic Materia Medica of the British Pharmacopœia, for the use of

MEDICAL AND PHARMACEUTICAL STUDENTS.

These Collections comprise all that a Student requires to assist him in preparing for his Materia Medica Examination. Each Collection consists of about 150 carefully selected and characteristic specimens of the Roots, Barks, Flowers, Fruits, Leaves, Resins, Gums, &c., of the British Pharmacopœia, 1867. Each Specimen bears a label containing a description of the source from which the article is derived, its natural order, characters and tests, dose, and the names of the Pharmacopœia Preparations into the composition of which it enters. The Student is thus enabled, in the most effective manner, to study Materia Medica with the actual substance as well as the descriptive text before him.

The Price of the Collection, in a neat wooden box, 30s. net. (The Copyright of these Collections is Registered.)

OPINIONS OF THE PRESS.

Favourable opinions have been received from the Editors of the MEDICAL TIMES AND GAZETTE, BRITISH MEDICAL JOURNAL, PHARMACEUTICAL JOURNAL, and CHEMIST AND DRUGGIST.

We have received a number of unsolicited letters, expressing warm approval of these Collections. The following are extracts from some of them:—

From Professor C. B. C. Tichborne.

"40, Mary Street, Dublin, 24th November, 1875.

"Gentlemen,—I have examined the case of specimens, and consider them invaluable for educational purposes. They are evidently chosen with great care, *and are in every case typical specimens.*

"Believe me, Gentlemen, yours very truly,
"CHAS. B. C. TICHBORNE."

From Manchester, April 20, 1876.—"The specimens ought to be in the hands of every medical student and chemist."

From Glasgow, February 24, 1876.—"I am very much pleased with them."

From Cork, April 7, 1876.—"The specimens are most useful. Several of my fellow-students said they would send for them."

From London, May 7, 1876.—"Your excellent collection to hand, with many thanks for its repleteness."

Besides the "Students' Set," we supply larger Collections for the use of Professors at Universities, Lecturers, &c., as the following letters show:—

From Prof. Geo. F. Duffey, Lect. on Mat. Medica, Dublin.

"Messrs. Southall Bros. & Barclay. "Dublin, March 18th, 1876.

"Gentlemen,—I received the specimens on Thursday. I am very much pleased with the collection you have sent. It is extremely neatly and well put up, and presents a remarkably good appearance in the Museum. The specimens all seem equally good and characteristic; and I think, considering the liberal quantity of each specimen sent, and the care and trouble that have evidently been taken in selection and arrangement, that the price is reasonable.—Yours obediently,
"GEORGE F. DUFFEY."

The following note is from Dr. P. W. Latham, Professor of Medicine, Cambridge University:—

"Cambridge, February 25th, 1869.

"Gentlemen,—Enclosed I send you a cheque for the amount due from me, I am extremely well pleased with the collection of vegetable specimens with which you have provided me, and am very much obliged to you for the trouble you have taken. In my lectures on Materia Medica I have shown my class your 'Students' Collection,' and strongly recommend each member to purchase one. You have conferred a great boon on Medical Students, by placing within their reach such a collection at so reasonable a rate.—Yours obediently,
"P. W. LATHAM."

Dr. Muter, Director of the South London School of Pharmacy (New Kennington Institute), writes:—

"289, Kennington Road, S.E., London, 14th September, 1871.

"Dear Sirs,—I am last night in receipt of the large set of specimens sent by you as an addition to our Museum of Materia Medica. They are exceedingly good and characteristic, and give me the greatest satisfaction. I will always in future desire my students to possess themselves of your 'Students' Set' for home study.—Yours faithfully,
"JOHN MUTER, Ph.D., M.A., F.C.S., Director."

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Date of First Registration, Nov. 24th, 1875, No. 296,333. Second do., July 10th, 1877, No. 311,772.

IMPORTANT NOTICE—JULY, 1877.

It having come to the knowledge of Mr. JAMES SWIFT, of University Street, London, that one of his registered Microscopes, similar to illustration, has been pirated, J. S. begs to caution all purchasers of Microscopes against these spurious imitations, which are of exceedingly inferior workmanship. As a greater precaution against this imposition, J. S. has appropriated a *Trade Mark*, a facsimile of which is herewith shown, which will be engraved upon every Instrument and important optical appliance which leaves his Establishment after this date. J. S. further begs to caution purchasers against buying second-hand Microscopes and Objectives bearing his name, as an unwarrantable liberty has been taken in affixing his name to such articles, and J. S. will have no objection to inspect, free of charge, any such Instruments or Objectives, to ascertain whether they are genuine.

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With eye-piece, 1-in. and ½-in. objectives, needle-points, thin glass covers and slides, in mahogany cabinet,

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Rack and pinion coarse adjustment can be adapted to this Instrument in place of sliding tube, extra £1 10s.

THE ABOVE MICROSCOPE

Has lately been improved by the suggestions of PROF. RUTHERFORD, Edinburgh University, to which College it is supplied; and is strongly recommended by Dr. PYE-SMITH, Guy's Hospital, London; PROF. MCKENDRICK, Glasgow; Dr. LIONEL BEALE, King's College; PROFS. BROWN and AXE, Royal Veterinary College, London; PROF. BOMMER, University, Brussels; &c., &c.

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MEDICATED GELATINE PREPARATIONS.

Discs for Hypodermic Injection of Morphia, Codeia, Ergotine, Atropia, Apomorphia, Morphia and Atropia combined, &c.

The following Important Additions have been made with special reference to Hydrophobia—viz., Curara Discs, 1-10th and 1-20th of a grain, used successfully in the treatment of Tetanus, &c. Also Veratria and Colchicia Discs, recently prescribed for Rheumatism. (For Cases of Tetanus treated at Guy's Hospital with Curara Discs, see *Medical Times and Gazette*, March 13th, 1877.)

N.B.—With reference to the dose of Curara, as mentioned in THE LANCET of Nov. 10th, we beg to observe that the Curara in our Discs is purified from all extraneous matter, and is, in fact, "Curarine;" consequently is more certain in its action. We therefore do not think it advisable at present to supply Discs of greater strength than the above-named, of which two or more can be used if required.—S. & M.

The chief features of these Discs are their instant solubility, by which hypodermic solutions can be immediately obtained of uniform and reliable strength; they keep good for an unlimited period in their dry state, and are extremely portable.

Discs for Ophthalmic Purposes are found more reliable than Collyria, and produce the desired effects with smaller quantities of medicaments, in consequence of their complete absorption. Amongst the Discs specially recommended are the following:—Atropine, Eserine or Calabar Bean, Zinc and Opium, &c., &c.

Lamels for Internal Administration, consist of thin pliable sheets of uniform thickness, accurately divided into squares by raised lines, each square containing an exact dose of the medicine with which the sheet is impregnated. These sheets may be carried in an ordinary pocket-book, and keep good in any climate. Those most generally used comprise Quinine, Opium, Opium with Ipecacuanha, Calomel, Santonine, Fluid Extract Ergot, Jalapine, Emetia (for Dysentery), &c.

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